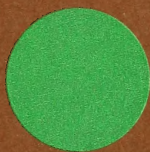


**LEGISLATIVE HISTORY
TITLES I-XX
OF THE
SOCIAL SECURITY ACT**

**Volume XXII
99th Congress
1985-1986
Part 2**



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Part 2

**Compiled by the
Technical Documents Branch
Division of Technical Documents and Privacy
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Office of Policy
Social Security Administration**

OMNIBUS BUDGET RECONCILIATION ACT OF 1986

R E P O R T

OF THE

COMMITTEE ON THE BUDGET HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 5300

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO SECTION 2 OF THE FIRST CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 1986

together with

SUPPLEMENTAL, ADDITIONAL, AND MINORITY
VIEWS



JULY 31, 1986.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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PROVIDING FOR RECONCILIATION PURSUANT TO SECTION
2 OF THE CONCURRENT RESOLUTION ON THE BUDGET
FOR THE FISCAL YEAR 1987

JULY 31, 1986.—Committed to the Committee of the Whole House on the State of
the Union and ordered to be printed

Mr. GRAY of Pennsylvania, from the Committee on the Budget,
submitted the following

REPORT

together with

SUPPLEMENTAL, ADDITIONAL, AND MINORITY VIEWS

[To accompany H.R. 5300]

[Including cost estimates of the Congressional Budget Office]

STATEMENT OF THE COMMITTEE ON THE BUDGET

The Committee on the Budget to whom reconciliation recommendations were submitted pursuant to section 2 of Senate Resolution 120, the Concurrent Resolution on the Budget for Fiscal Year 1987, having considered the same, reports a bill embodying those recommendations.

VOTE OF THE COMMITTEE IN REPORTING THE BILL

In compliance with clause 2(1)(2)(B) of rule XI of the Rules of the House of Representatives, the following statement is made relative to the vote of the Committee in reporting the bill. H.R. 5300 was ordered reported by the Committee on July 31, 1986, by a voice vote, with a quorum being present.

BUDGET AUTHORITY AND COST ESTIMATES, INCLUDING ESTIMATES OF
CONGRESSIONAL BUDGET OFFICE

In compliance with clause 7(a) of rule XIII and clause 2(1)(3)(C) of rule XI of the Rules of the House of Representatives, the Commit-

[(A) each corporation within such industry which is identified under section 373 fully participates in such program;

[(B) all information deemed necessary by the Secretary for purposes of evaluating the progress made by such industry in achieving the industry energy efficiency improvement target set forth under section 374 is provided to the Secretary; and

[(C) reports made to a trade association or other person, in connection with such program, are retained for a reasonable period of time and are available to the Secretary.

[(2) If the Secretary determines that an industry's voluntary reporting program is not adequate solely on the basis that any corporation within such industry is not fully participating in such program, he shall exempt from the requirements of section 375(a) only those corporations which fully participate in such program.

[(h) Nothing in this part shall limit the authority of the Secretary to require reports of energy information under any other law.]

* * * * *

REPORT TO ACCOMPANY RECOMMENDATIONS FROM THE COMMITTEE ON ENERGY AND COMMERCE (HEALTH MATTERS)

Medicare, Medicaid, and Maternal and Child Health Budget Reconciliation Amendments of 1986

PURPOSE AND SUMMARY

The purpose of the amendments reported by the Committee is to achieve net expenditure reductions in Part B of the Medicare program, which in combination with changes recommended by the Committee on Ways and Means in Part A of the Medicare program, will achieve the reconciliation targets established in the Concurrent Budget Resolution for FY 1987, S. Con. Res. 120; and to provide legislative authority to achieve certain program improvements in the Medicaid and Maternal and Child Health programs which were specified in the Budget Resolution.

BACKGROUND AND NEED FOR LEGISLATION

The Concurrent Resolution on the Budget for FY 1987 provided for a reduction in Medicare expenditures in Parts A and B of the program of \$550 million in FY 1987, and \$3.3 billion over the next three fiscal years. The House Resolution specified that these program savings were to be achieved in a manner which did not increase costs to, or reduce services for, program beneficiaries. The Budget also made provision for increased funds in Medicare of \$250 million in FY 1987 and \$1 billion over the next three fiscal years to moderate increases in the Medicare hospital deductible.

Jurisdiction over the Medicare program is shared between the Committees on Ways and Means (Parts A and B of Medicare) and Energy and Commerce (Part B of Medicare). The reconciliation instruction for expenditure reduction is assigned in full to both Committees with the understanding that the combined actions of both Committees will determine if the reconciliation target is met. The amendments considered by the Energy and Commerce Committee

are designed to make improvements in the Medicare program, to protect the beneficiary against increased costs or reductions in services, and to achieve sufficient net reductions in part B expenditures that, when combined with the effect of the actions of the Ways and Means Committee, the reconciliation instruction for the Medicare program are met.

Further, the Budget Resolution contained funds for increased services under the Maternal and Child Health Services Block Grant found in Title V of the Social Security Act and for specified improvements in the Medicaid program which would allow aged and disabled persons below the poverty line, and poor pregnant women and infants up to age 1, to have access to Medicaid services at State option. In addition, the Resolution provided funds to hold States harmless in FY 1987 for loss of funds resulting from changes in the matching formula for Medicaid which were adopted as part of the Consolidated Omnibus Budget Reconciliation Act, P.L. 99-272, enacted earlier this year. The amendments considered by the Committee were in response to these specific initiatives included in the budget.

An explanation of the amendments to existing law recommended by the Committee follows:

SUBTITLE F—MEDICARE

Provisions Relating to Parts A and B

Direct costs of graduate medical education (Sec. 4501)

Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") restructured the manner in which Medicare reimburses teaching hospitals for the direct costs they incur for graduate medical education. Effective with cost reporting periods beginning on or after July 1, 1985, hospitals are to receive payment on the basis of a formula that takes into account each hospital's previous average cost per full-time equivalent resident, the number of full-time equivalent residents during the period for which reimbursement is being made, and the hospital's proportion of total inpatient days used by Medicare patients during that period. Beginning on July 1, 1986, distinctions are made among residents, for purposes of counting their full-time equivalency in this formula, and different weighting factors are applied depending on how many years of residency training they have completed. Residents are weighted at 1.00 during the period needed to obtain their first board eligibility, plus one additional year, not to exceed a total of five years. As a practical matter, this results in full payments for either four or five years. After that period of residency, payments are reduced. Beginning on July 1, 1987 payments for such residents are reduced to 50% of what they would otherwise have been.

Section 4501 of the Committee bill makes two changes in these new rules, with respect to how residents are counted towards full-time equivalency. These two changes are designed to enhance the incentives for training in primary care. The first change relates to the patient care settings in which the resident may be located and

counted towards full-time equivalency; the second relates to the weighting factor used during the fifth year of residency.

Under current Medicare regulations, a resident's time spent in an ambulatory setting is counted towards full-time equivalency only if the setting is, organizationally, part of the hospital where the resident's training program is located. If the resident is assigned to a free-standing setting, such as a family practice center or clinic or a free-standing ambulatory surgery center, no Medicare payments are allowed for the time spent there. Since it is difficult to find sufficient other sources of funding for the costs of such training, assignments to these settings are discouraged. It is the Committee's view that training in these settings is desirable, because of the growing trend to treat more patients out of the inpatient hospital setting and because of the encouragement it gives to primary care.

The Committee bill would change the current regulations by providing that all of the time that a resident spends in activities related to patient care is to be counted towards full-time equivalency, without regard to the setting in which those activities take place, so long as the hospital is incurring costs for that resident's training. Payments would continue to be made only to the hospital; they would not be made directly to independent, free-standing units. Such units would have to have a financial arrangement with the teaching hospital, under which the hospital incurs costs for such items as the resident's salary or stipend, the faculty, supervisors or administrators of the residency program, or the other items that are presently included under direct medical education costs.

The Committee bill would also change the weighting factors used to compute full-time equivalency. Beginning on July 1, 1987, residents in the fifth year of their training who are weighted at 1.00 under the current law would be given a reduced weighting factor. The twelve month period beginning July 1, 1987, would be a transition year during which such residents would be given a weighting factor of 0.75. Beginning on July 1, 1988, and thereafter, such residents would be given a weighting factor of 0.50, which is the same as that given to other residents in the fifth, sixth, and succeeding years.

As was discussed in the Committee's report on the structural changes made in COBRA (H. Rept. 99-265, Part 1, pp. 66-73), primary care training programs have more difficulty obtaining resources than other programs, and they are more vulnerable to the cost-cutting measures currently being employed throughout the health care sector. As a result, opportunities for primary care training might be curtailed, for reasons having nothing to do with the training and career interests of residents or with the relative scarcity or surplus of particular specialties and subspecialties. The two changes in the Committee bill are designed to reinforce and enhance the objectives of the changes made by COBRA.

Cost limits for home health agency services (Sec. 4502)

Under regulations published by the Secretary on July 5, 1985, the methodology for calculating home health cost limits was revised, effective July 1, 1985, to require that such limits be applied on a discipline-specific basis. Prior to that time, separate limits

were established for each type of service provided, but they were applied in the aggregate to each home health agency based on a mix of services.

The Committee bill would restore the methodology for determining home health cost limits to that which was in place prior the publication of the July 5, 1985 regulations. Under the bill, cost limitations would have to be applied on an aggregate basis for all home health services furnished by an agency, rather than on a discipline-specific basis. The Secretary would be precluded from applying limits separately for each type of home health service provided and would be required to allow agencies to aggregate these limits and apply them to aggregated costs. The bill would also require that the Secretary provide for an adjustment to these limits as they apply to hospital-based agencies so as to account for the higher administrative costs that are incurred by such agencies.

In addition to reinstating the methodology for the application of home health cost limits, the Committee bill would require the Secretary to base such limits on the most recent data that are available. However, these data could not include information from cost reporting periods beginning before October 1, 1983. That is the date that the new Medicare prospective payment system for hospitals began to be implemented, and began to affect the needs of patients being served by home health agencies. The Secretary would also be required to take into account the changes in costs of home health agencies in billing and verification procedures that may result from the Secretary's changing or modifying the requirements for such procedures, to the extent the changes in costs are not reflected in the data.

Under the Committee bill, the Comptroller General is required to report to Congress by April 1, 1987 on the appropriateness and impact on Medicare beneficiaries of applying cost limits on a discipline-specific basis rather than on an aggregate basis for all home health services provided by an agency, as well as on the appropriateness of the percentage limits for such services as established by the Secretary.

Research on patient outcomes (Sec. 4503)

A growing body of research on the utilization of medical services has shown there to be extraordinary variations in the scope of care furnished to otherwise comparable populations. This is true for the general population and for Medicare enrollees, in particular. Such research raises questions that have an important bearing on policy decisions affecting the Medicare program. These include questions about the quality of care, the appropriateness of care, and the cost-effectiveness of care being received by Medicare enrollees and the effects of the payment methodologies and quality assurance measures currently employed.

The existing research raises such questions in a direct and forceful manner, but does not provide answers. We now know that hospital admissions or surgical rates for certain diagnoses, and average per capita expenditures for health care, vary by multiples of two, three, or four, from one community to another. However, we do not know the causes for such variations, what the effects of such variations are on patient outcomes, or what the proper rates of uti-

lization should be. Many procedures in common use have not been rigorously evaluated, and there is not a general consensus on the proper criteria and measures of quality and patient outcome. Individual physicians, each acting in good faith, in the best interests of the patient, and on the best information and knowledge available to them, can arrive at widely divergent conclusions about the best course of treatment. Such differences can result in vastly different effects on the quality, outcome, and costs of care.

The Committee bill requires the Secretary to conduct research on patient outcomes and selected medical treatments and procedures, for the purpose of improving our ability to address these issues in an informed manner. Funding is provided from the Part A and Part B trust funds, to be used for grants and cooperative agreements with the research community. The program would be administered by the National Center for Health Services Research and Health Care Technology, under the Assistant Secretary for Health. In administering the program, the National Center would be required to consult with the Center for Health Care Technology recently established, with Federal matching funds, under the auspices of the Institute of Medicine. Priorities and objectives for the research program are further identified in the provision.

Methodologically sound research on these policy-relevant, unanswered questions will be of tremendous assistance as the Committee reviews proposals for further modifications and refinements in the Medicare program. The Committee is concerned that a continuation of recent cost-saving measures, such as freezes or across-the-board reductions in payments for hospital, physician and other services, will have an adverse effect on the accessibility and quality of care needed by Medicare enrollees. It is the Committee's view that significant savings might be achievable in the future, without such adverse effects, if our efforts are grounded on rigorous research of the type called for in this provision.

Treatment of group purchasing vendor agreements (Sec. 4504)

Under current law, it is a felony to pay any remuneration, including any kickback, bribe, or rebate, with the intent of inducing or arranging for the referral of Medicare or Medicaid business. Sections 1877(b) and 1909(b) of the Act make conviction for such conduct punishable by a fine of up to \$25,000 and imprisonment of up to 5 years, or both.

Group purchasing organizations (GPO's) purchase goods and services for participating hospitals and other institutions at costs below those which the members would be able to obtain individually. To cover costs, GPO's either charge administrative fees to member institutions, or they require vendors from whom they purchase services or supplies to pay them a fixed percentage of the value of the business that they refer to the vendors. The Inspector General of the Department of Health and Services has determined that this latter arrangement—the vendor-paid fee—represents a "technical" violation of the anti-kickback provisions. In the IG's view, both the vendor who agrees to such a condition and a GPO who solicits such an agreement are violating the law. The IG does not consider these payments exempt from criminal liability as "discounts" under sections 1877(b) and 1909(b) of the Act because they

are not reductions in price, the value of which are passed on to the purchaser. Under group purchasing agreements, the amount paid by the vendor to the agent may not be passed along to the hospitals.

Pending Congressional clarification on this point, the IG requested that the Justice Department announce it would refrain from prosecuting such arrangements, but the Department, by letter dated October 30, 1985, declined, arguing that "this would be tantamount to saying that conduct which Congress in its wisdom has made a crime is not a crime." It is clear that Congressional action is warranted.

The Committee believes that GPO's can help reduce health care costs for the government and the private sector alike by enabling a group of purchasers to obtain substantial volume discounts on the prices they are charged. The Committee understands that the amount of the price reductions exceeds the fees the vendors must pay the GPO's. The Committee can see no justification for prohibiting such cost-saving arrangements, and believes that the uncertainty resulting from the Justice Department's position on this issue should be eliminated.

The Committee bill therefore creates an exception to the anti-kickback provisions for amounts paid by vendors of goods and services to authorized purchasing agents for groups of hospitals, nursing homes, or other entities receiving Medicare and Medicaid reimbursement, if the following conditions are met. First, the purchasing agent must have a written contract with each vendor and with each Medicare or Medicaid provider or practitioner in the group specifying the amount paid to the agent. The amount may be either a fixed sum or a fixed percentage (not to exceed 3 percent) of the value of the purchase made by each practitioner or provider under the contract. Second, the purchasing agent must disclose to each practitioner or provider in the group the amount received from each vendor with respect to that individual's or entities purchases. These limitations are intended to assure that only reasonable and above-board vendor-paid GPO fee arrangements receive the protection of this exclusion.

The purpose of this provision is to assure GPO's and the vendors who contract with them, that they do not risk prosecution as a result of the fees the GPO's collection from the vendors. The provision is therefore effective with respect to payments made before, on, or after enactment.

*Improvements in civil monetary penalty and exclusion provisions
(Sec. 4505)*

Under current law, practitioners and institutions who present false or certain other improper claims or requests for reimbursement under the Medicare, Medicaid, or Maternal and Child Health Services programs are, in addition to potential criminal penalties, subject to civil monetary penalties of up to \$2,000 for each item or service and, in lieu of damages an assessment of up to twice the amount claimed. Civil money penalty proceedings are prosecuted by the Inspector General of HHS before an administrative law judge; providers may appeal adverse determinations to the appropriate U.S. Circuit Court of Appeals. In addition, individuals who

have been convicted of criminal offenses related to their participation in Medicare or Medicaid are subject to exclusion from both programs; these individuals are entitled to an administrative hearing and, if the agency upholds the IG's decision to exclude, judicial review.

The Committee bill makes three improvements in these authorities that are intended to increase the efficiency of these proceedings. First, the bill expands the application of the doctrine of collateral estoppel in civil monetary penalties cases. Under this doctrine, a person who is convicted of a criminal offense after a trial, by virtue of a plea of guilty, cannot relitigate the essential elements of the criminal offense in a subsequent civil case, including a civil monetary penalties case. The doctrine is based on the principle that it is wasteful to relitigate issues which have already been resolved in another proceeding. The Committee does not intend to narrow the application of the collateral estopped doctrine in any respect, and intends to expand its application in one respect, by allowing its application where an individual has entered a plea of *nolo contendere* in a Federal criminal prosecution. It is as wasteful of the IG's limited resources to relitigate the essential elements of a criminal offense when the defendant as entered a *nolo* plea as when the defendant has plead guilty. The Committee intends that application of the doctrine of collateral estoppel in this manner should govern civil monetary penalty proceedings notwithstanding any other provision of Federal law with respect to such pleas.

Second, the Committee bill provides administrative law judges in civil monetary penalties proceedings the authority to impose limited sanctions on any party or attorney for failure to comply with lawful orders, for failing to defend an action, or for other misconduct that would interfere with the speedy, orderly, or fair conduct of the hearing. It is the understanding of the Committee that, in some civil monetary penalties cases, parties or their attorneys have failed to comply with discovery orders, time deadlines, and other lawful orders of the administrative law judge, who under current law lacks the authority to sanction such misconduct effectively. The Committee bill provides administrative law judges in such circumstances with a range of sanctions, such as the drawing of negative factual inferences from the failure to allow discovery, striking pleadings or defenses, staying the proceedings, dismissing the action, entering a default judgment, ordering the party or attorney to pay the cost caused by the misconduct, or refusing to consider any document not filed on time. Any sanction imposed must be reasonably related to the severity and nature of the misconduct. The imposition of any such sanction is, of course, subject to appeal in conjunction with any appeal of the decision on the merits of the case to the U.S. Circuit Court of Appeals.

Finally, the Committee bill defines the term "convicted" for purposes of the exclusion of individuals convicted of program-related criminal offenses under section 1128(a) of the Act. An individual is considered to have been convicted of a criminal offense when (1) a judgment of conviction has been entered in a local, State, or Federal Court, regardless of whether there is an appeal pending or whether the judgment or other record of conviction has been expunged; (2) there has been a finding of guilt by a Federal, State, or

local court; (3) a plea of guilty or nolo contendere has been accepted by a Federal, State, or local court; or (4) the individual has entered into participation in a first offender, deferred adjudication, or other program where judgment of conviction has been withheld.

With respect to convictions that are "expunged," the Committee intends to include all instances of conviction which are removed from the criminal record of an individual for any reason other than the vacating of the conviction itself, e.g., a conviction which is vacated on appeal. The Committee wishes to emphasize that, if a conviction is overturned or vacated on appeal, the individual can no longer be excluded from the Medicare and Medicaid programs (unless, of course, he or she has been excluded on grounds independent of such conviction).

According to the Office of the Inspector General, about 10 percent of the criminal dispositions of cases of criminal abuse against Medicare or Medicaid cannot be the basis for an exclusion under current law. In FY 1985, of 447 criminal dispositions obtained by the State Medicaid fraud control units, 49 convictions were found to be outside the scope of section 1128(a); accordingly, there was no Federal exclusion from Medicare or Medicaid in these cases.

The principal criminal dispositions to which the exclusion remedy does not apply are the "first offender" or "deferred adjudication" dispositions. It is the Committee's understanding that States are increasingly opting to dispose of criminal cases through such programs, where judgment of conviction is withheld. The Committee is informed that State first offender or deferred adjudication programs typically consist of a procedure whereby an individual pleads guilty or nolo contendere to criminal charges, but the court withholds the actual entry of a judgment of conviction against them and instead imposes certain conditions of probation, such as community service or a given number of months of good behavior. If the individual successfully complies with these terms, the case is dismissed entirely without a judgment of conviction ever being entered.

These criminal dispositions may well represent rational criminal justice policy. The Committee is concerned, however, that individuals who have entered guilty or nolo pleas to criminal charges of defrauding the Medicaid program are not subject to exclusion from either Medicare or Medicaid. These individuals have admitted that they engaged in criminal abuse against a Federal health program and, in the view of the Committee, they should be subject to exclusion. If the financial integrity of Medicare and Medicaid is to be protected, the programs must have the prerogative not to do business with those who have pleaded to charges of criminal abuse against them.

Payment for ESRD services (Sec. 4506)

Under special eligibility provisions enacted in 1972, virtually everyone who is diagnosed as having end-stage renal disease is eligible to enroll in Medicare, irrespective of age or disability status. Specific services covered for such enrollees include dialysis service and transplants, as well as hospital and physician services. Special payment methodologies have been instituted for dialysis and physi-

cian services, which are designed to provide incentives for home dialysis and promote the most cost-effective mode of treatment.

Dialysis services are paid on the basis of a prospectively determined, composite rate per treatment, that is weighted to take into account the mix of home and out-patient facility patients and the relative costs of those two settings. Separate rates are set for hospital-based and for free-standing facilities. These rates were first established by regulations published by the Health Care Financing Administration on May 11, 1983, and have remained in effect without change since that date. On May 13, 1986, HCFA published a proposed notice, setting forth its intent to change the methodology by which such rates are calculated, as well as apply more recent data in calculating the rates. Under HCFA's proposed changes, the base rate for free-standing dialysis facilities would be decreased from \$122.91 per treatment to \$113.47, and the base rate for hospital-based facilities would be decreased from \$126.76 to 117.89.

Considerable concern has been expressed by patients, physicians, dialysis facilities and others about the effect that such a decrease will have on the quality and access of dialysis services. Although the Committee recognizes that cost-saving changes in technology and dialysis practices, as well as increases in the proportion of patients dialyzing at home, have probably reduced the costs of dialysis, the Committee is concerned that reductions of the magnitude proposed by HCFA may have an adverse effect on patients. Information does not exist at this time to resolve this concern conclusively.

The Committee bill would authorize the Secretary to reduce the composite rates, but not below a base rate of \$117.50 for free-standing facilities and \$121.50 for hospital-based facilities. The bill also requires the Secretary to arrange for an independent study of the effects of any reductions in these rates and to report the findings to Congress by January 1, 1988. It is the Committee's intention that the study be conducted by the Institute of Medicine, if that body is willing to do it.

The Committee bill would also amend the statute to require prompter consideration of requests for exceptions from these dialysis rates. The statute currently requires the Secretary to provide for additional payments to dialysis facilities that cannot avoid incurring costs greater than the composite rates, due to unusual circumstances. The Secretary is to give special consideration to sole facilities located in isolated, rural areas. Numerous complaints have been received, however, that the exceptions process is cumbersome, that the rules are ambiguous and difficult to comply with, and that determinations are long delayed. Essential isolated facilities and pediatric facilities, which also have special needs, have been particularly affected.

To resolve this concern, the bill includes a provision that would add pediatric facilities to those warranting special consideration and require that exceptions be resolved within 45 working days after being filed. If an exception were not resolved at that time, it would be deemed to be approved. It is the Committee's intent that HCFA clarify the requirements that an essential isolated facility or a pediatric facility must meet in order to receive an exception and that the process be simplified and expedited for these applicants. It

is the Committee's expectation that, if this is done, applications for exceptions will not have to be returned to the applicant for failure to provide the necessary information and documentation for an exception.

Under current law, payments for routine physician services are made on the basis of a monthly capitation payment ("MCP"). This concept has been used to compensate physicians since 1974, with the current methodology established by HCFA in regulations published on May 11, 1983. The rates originally put into effect in 1974 were increased marginally in 1978, but were significantly reduced when the current methodology was adopted in 1983. On July 2, 1986, HCFA revised the current methodology, to be effective August 1, 1986, which would have the effect of reducing the MCP, on average, from \$187.88 to \$173.07.

As was the case with HCFA's proposed reductions in dialysis rates, this reduction in the MCP has been criticized by patients, physicians, and others, for being too large and having an adverse impact on the care furnished ESRD patients. As before, the Committee shares this concern and has very little information on which to draw a conclusion as to what is the most appropriate level of payment and what the effects will be of the proposed reduction. The bill would permit the Secretary to reduce the MCP, so long as it is done in a manner that the average payment was not less than \$180. The bill also incorporates the effects of MCP reductions in the study described above, to be done by the Institute of Medicine.

The Committee bill also includes Medicare coverage of immunosuppressive drugs for enrollees who receive an organ transplant that is covered under Medicare, which at this time would include kidney and heart transplants. The period of coverage is limited to one year following the transplant operation. (If a Medicare enrollee were to require a second transplant, coverage for these immunosuppressants would extend to the second transplant, for a period of one year following the second transplant.) Payment would be made under Part B on a reasonable charge basis, subject to the standard deductible, coinsurance, and other features of the reasonable charge methodology. It is the Committee's expectation that transplant centers will facilitate the patient's obtaining and billing for these drugs.

The Committee sought to provide Federal payments for immunosuppressive drugs two years ago, when reporting the National Organ Transplant Act. The Committee concluded that it was not sound policy for Medicare to pay for an expensive transplant procedure, but not pay for the drugs that are essential for the transplant to be a success. (See H. Rept. 98-769, pp. 12-14.) In conference, it was agreed instead to have the Task Force on Organ Transplantation review and make recommendations on this issue. The Task Force did so, and recommended unequivocally that Federal funds be used to provide these drugs. (See Report to the Secretary and the Congress on Immunosuppressive Therapies, October 1985.)

The Committee has concluded that, in light of the demonstrated need for, and special circumstances regarding, these drugs, we should not continue to withhold Medicare payments on the grounds that Medicare does not otherwise pay for self-administered, outpatient drugs.

Improvements in ESRD networks (Sec. 4507)

The End-Stage renal disease networks are organizations formed to promote access and quality in dialysis services. There are currently 32 such networks. These networks have performed a variety of functions, including obtaining and validating data on dialysis and transplant patients, resolving patient grievances about the services they are receiving from dialysis facilities, and working with dialysis facilities, physicians and patients to monitor and improve the quality of care and promote the most appropriate mode and setting for dialysis services for each patient.

On April 15, 1986, the Health Care Financing Administration published a proposed rule in the Federal Register, which would revamp the current network organizations. In addition to reducing the number of networks to 14, HCFA proposed to change from a grant arrangement to competitively bid contracts. The proposal would have removed most of the requirements regarding network duties and responsibilities from the regulations, in order to have the flexibility to define and negotiate these issues during the contracting process.

The HCFA proposal has been severely criticized by patients, physicians, and dialysis facilities, because of their concerns that it will result in the elimination or diminution of the vital functions currently performed by networks. These groups also express the view that a reduction to 14 networks will result in geographical areas that are too great to allow for the effective performance of network functions.

In response to these concerns, the Committee bill would preclude HCFA from carrying out its proposal. Further, the bill would amend the current statute to strengthen the networks' legislative mandate to perform the data collection, patient grievance, and quality assurance functions now performed and to place greater emphasis on vocational rehabilitation of dialysis patients. The bill would require the Secretary to follow specified procedures in making changes in the networks, would allow consolidation of existing network areas to no fewer than 17, and would provide that existing network organizations, or combinations of existing network organizations, are to be given the first opportunity to perform the network functions in a newly designated area. Beginning on January 1, 1987, networks would be funded by HCFA taking 50 cents from the payment that would otherwise be made to a dialysis facility for dialysis services under the prospective, composite rate payment method. This would replace the current method of funding from the Medicare trust funds, subject to a specific appropriation.

The bill would also require the Secretary to establish a national end-stage disease registry, for the purpose of collecting uniform and comprehensive data on all dialysis and transplant patients. The Secretary would be responsible for analyzing such data, making it available (in such a manner as to protect the confidentiality of individual patients) for others to conduct research and analyses, and making an annual report to the Congress on the status and recent developments in the ESRD program. It is the Committee's intent that the requirements established in this provi-

sion be followed by the Secretary in carrying out the requirements for a scientific registry established in title II of the National Organ Transplant Act (section 373 of the Public Health Service Act).

Improvements in organ procurement activities (Sec. 4508)

The Task Force on Organ Transplantation, created by the National Organ Transplant Act of 1984 (P.L. 98-507), conducted a comprehensive examination of all aspects of organ procurement and transplantation. In addition to many other findings and specific recommendations, the Task Force concluded that an overriding problem, common to all organ transplant procedures, is the serious gap between the need for organs and the supply of organs available for transplantation. The Task Force found that many opportunities for obtaining organs were lost because of oversights or shortcomings in the present procurement process. Specific recommendations adopted by the Task Force included a requirement that all hospitals, as a condition of participation in Medicare, adopt "routine inquiry" policies and procedures for identifying potential donors and providing next-of-kin with appropriate opportunities for donation. Another recommendation was that organ procurement agencies be strengthened by establishing criteria which they must meet in order to be certified and by recertifying them on a periodic basis. (See *Organ Transplantation*, Report of the Task Force on Organ Transplantation, April 1986, pp. 31-34, 59-61.)

The Committee bill incorporates both of these recommendations. First, it would require that all hospitals, as a condition of participation in Medicare or Medicaid, adopt "routine inquiry" protocols for identifying and assisting potential organ donors. The Committee notes the distinctions made in the Task Force report between "routine inquiry" and "required request", and intends for the provision to be implemented accordingly. The hospitals are to carry out this provision with discretion and sensitivity to the circumstances, views, and beliefs of the next-of-kin of the organ donor.

Second, the bill precludes Medicare and Medicaid payments for organ procurement, if the organ procurement agency does not meet specified standards. In order to satisfy this requirement, the procurement agency must either qualify for a grant under title II of the National Organ Transplant Act, or meet the standards set forth in title II without having received a grant, or meet the standards established by the Association of Independent Organ Procurement Agencies. These latter standards are comparable to those set forth in title II and were favorably reviewed by the Task Force. Those agencies that did not have grant would have to be recertified as meeting required standards at least every two years.

COBRA technical corrections (Sec. 4509)

The bill would make several technical corrections that have been identified in the implementation of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272).

The first deals with payments for the direct costs of graduate medical education. It would clarify that the special transition rule, under which foreign medical graduates who were in residency programs before July 1, 1986 but who have not passed the requisite

qualifying examination may be counted at a reduced rate, would last only for the twelve month period ending on June 30, 1987.

The second deals with the payment level set for health maintenance organizations and competitive medical plans. COBRA required that these rates be published in the Federal Register each year by a certain date. In response to concerns expressed about delays caused by the clearance process for publishing items in the Federal Register, the bill would allow HCFA to announce these rates in notices to the affected parties, in lieu of publication in the Federal Register.

The third correction would clarify that prohibitions against billing for unauthorized services of assistants at surgery apply to both assigned and non-assigned claims.

The fourth correction, also affecting the assistant at surgery provision, is needed because the carrier and PRO systems are not yet in place to make pre-procedure review of the need for such services, as required under COBRA. It would authorize post-procedure review until November 15, 1986.

The fifth provision would extend the "Access: Medicare" demonstration project for an additional 10 months.

Several other coding, numbering and cross-reference corrections would also be made.

Waiver of the 50 percent enrollment requirement for HMOs (Sec. 4510)

Current law requires that health maintenance organizations and competitive medical plans, in order to qualify for risk contracts under Medicare, must enroll sufficient private patients that the proportion of Medicare and Medicaid enrollees does not exceed 50 percent of their total enrollment. Current law also allows the Secretary to waive this requirement if special circumstances warrant such a waiver and the HMO or CMP is making reasonable efforts to enroll the requisite number of private patients.

Concerns have been expressed to the Committee about the manner in which this waiver authority has been exercised, as well as about the failure of some HMOs to make sufficient efforts to bring their private enrollment into balance with their Medicare and Medicaid enrollment. The bill amends the requirements for obtaining a waiver, by authorizing the Secretary to waive the 50 percent rule only to the extent that the population in the area being served by the HMO or CMP consists of more than 50 percent Medicare and Medicaid eligible persons.

Current law authorizes the Secretary to terminate a risk contract with an HMO or CMP under specified circumstances. However, the Department has noted that it does not have authority to take appropriate corrective actions, short of termination, if the HMO or CMP fails to meet the requirements of the Medicare law. The bill, therefore, provides authority for the Secretary to suspend Medicare payments for new enrollees, if the Secretary finds that the HMO or CMP has failed to satisfy the requirements of the 50 percent enrollment rule.

*Provisions Relating to Part B**Vision care (Sec. 4521)*

Under current law, Medicare will reimburse for eye examination services furnished by an ophthalmologist, or by another doctor of medicine or osteopathy, to a patient with a complaint or symptom of eye disease or injury. Medicare will reimburse for examination services furnished by an optometrist, however, only if the services are related to the condition of aphakia. Medicare will not pay for eyeglasses or for eye examinations for the purpose of prescribing, fitting or changing eyeglasses (except in the case of prosthetic lenses for aphakic patients). Payment is denied for all refractive procedures, even if performed in connection with the diagnosis or treatment of an eye disease or injury or for the purpose of prescribing prosthetic lenses.

The Committee has held two hearings at which these coverage rules were examined. On both occasions, the Committee was advised that these rules are impinging on beneficiaries' access to needed eye care. Many beneficiaries are either foregoing covered eye care or are paying out-of-pocket for eye care services furnished by optometrists, because they do not have ready access to an ophthalmologist and because the present rules are too difficult to understand.

The Committee bill would allow medicare payments for eye examination services furnished by optometrists, subject to two prerequisites. The service must be one which is currently covered by medicare if furnished by a doctor of medicine or osteopathy and it must be within the services the optometrist is authorized to perform under the licensure laws of the State in which the service is performed.

The bill would not expand or change the current coverage and reimbursement rules in any other manner. To be reimbursed, the services would, as under current law, have to be reasonable and necessary for the diagnosis of an injury or disease. The current, generally applicable rules for reasonable charge reimbursement would be used to determine payments to optometrists. It is the Committee's expectation that the medicare carriers, with guidance from the Health Care Financing Administration, would use information regarding payments they make for optometrists' services under their own health plans, or other appropriate information, to establish the initial customary and prevailing charge screens.

Occupational therapy services (Sec. 4522)

Occupational therapy is a medically prescribed therapy concerned with improving or restoring functions of an individual who has been impaired by illness or injury or, when functions have been permanently lost or reduced by illness or injury, with improving the individual's ability to perform those tasks required for independent functioning.

Under current law, medically necessary occupational therapy services are covered under part A of Medicare when provided as a part of covered inpatient hospital services or post-hospital extended care services in a skilled nursing facility, or as part of home health services or hospice care. Part B coverage is limited to treatment in

a hospital outpatient department, comprehensive outpatient rehabilitation facility, home health agency or when incident to a physician's service.

The Committee bill would extend reimbursement under part B of medicare for occupational therapy services. Occupational therapy would be covered when provided in a skilled nursing facility (when part A coverage is exhausted), in a clinic, or a rehabilitation agency. Payment for services in these settings would be made on a reasonable cost basis.

In addition, occupational therapy services would be covered when furnished in a therapist's office or a beneficiary's home, if the therapist met licensing and other standards prescribed by the Secretary. No more than \$500 in incurred expenses would be eligible for coverage in a calendar year per beneficiary. Payment for these settings would be based on 80% of reasonable charges.

Generally speaking, the bill would make medicare coverage of occupational therapy services comparable to the existing coverage of physical therapy services.

The Committee believes that the value of occupational therapy services to beneficiaries merits a modest expansion of the program. Further, the Committee finds that such services have the potential to reduce and avoid the need for institutional care, while enabling the beneficiary to function more independently.

Services furnished by physician assistants (Sec. 4523)

Under current law, the services of physician assistants are not explicitly recognized, and no specific payment is authorized under Medicare for such services, except in the case of rural health clinics. The revised conditions of participation for hospitals, published by the Health Care Financing Administration on June 17, 1986, acknowledge that such services are appropriate and hospitals may use them without jeopardizing their participation in Medicare. However, the hospital would not receive any reimbursement for such services and would have to pay physician assistants out of the hospital's PPS payment. This clearly discourages the use of these services.

Physician assistants might also be utilized in physician's offices under the "incident to" rules of Medicare, but no payment is authorized under Medicare other than that billed by the physician as part of the services he personally performed. Again, this discourages the use of such services.

The Committee bill would authorize Medicare payments for the services of physician assistants, under specified circumstances. The Committee believes that such services can provide increased access to physician services, in a cost-effective manner, without a diminution in quality. The experience to date with rural health clinics has indicated this to be true. When the Congress passed the Rural Health Clinic Act in 1978, it called for HCFA to conduct a demonstration of the use of physician extenders in urban clinics. That demonstration has been undertaken, but the results are not yet available to us. However, we have been informed of some preliminary information regarding a demonstration project involving the use of physician assistants in nursing homes. The experience there suggests that such services can result in lower utilization of hospi-

tal services, increased access to physician services, no apparent effect on quality, and possible reductions in the overall cost of care.

The bill would authorize Medicare reimbursement with respect to physician assistant services performed in a hospital or skilled nursing facility or as an assistant at surgery, when these services are furnished in conformance with all applicable Federal and state laws. Thus, the services would have to meet State laws regarding the licensure, scope of practice, and medical direction of physician assistants. In addition, for example, payment would be authorized for services as an assistant at surgery, only if the services of such an assistant were necessary in the particular case.

In authorizing payments for these services furnished in skilled nursing facilities, the Committee is responding to concerns that patients in such facilities may have restricted access to physician services. Therefore, the Committee would not want the intent of this provision to be thwarted by interpretations of existing laws or regulations, including the conditions of participation for SNF's that might preclude physician assistants from furnishing services they are qualified to perform under state law. Because physician assistants necessarily furnish services under the direction of a physician, the Committee expects that the services of physician assistants will be recognized under this provision to the fullest extent possible.

In view of the fact that physician assistants cannot practice independently, the bill would not authorize them to bill directly under Medicare. Non-assigned claims would continue to be billed by the beneficiary. Assigned claims could be billed only by the physician, hospital, nursing home, or other employer of the physician.

Payment would be made on a reasonable charge basis under Part B. The bill would establish an upper limit on such reasonable charges, at 90% of the prevailing charge applicable to physicians' charges for the same service in the same locale. This is not intended to authorize the Secretary to set lower limits on payments for the services of physician assistants.

Services of nurse anesthetists (Sec. 4524)

The services of certified registered nurse anesthetists ("CRNAs") are currently recognized as appropriate services under the Medicare program and arrangements are made for Medicare reimbursement. However, under current law, CRNAs cannot be reimbursed directly by Medicare.

Prior to the implementation of the Medicare prospective payment system for hospitals, hospitals were reimbursed on a cost basis for CRNA services if the CRNA was employed by, or under contract with, the hospital. When the PPS was initially instituted, CRNA services were incorporated in the services to be included within the PPS "DRG" payment. This had the effect of discouraging the use of CRNA services, even though they are appropriate, high-quality, and cost-effective services. In section 2312 of the Deficit Reduction Act of 1984, the Congress sought to resolve this issue on an interim basis, pending further reform in physician or anesthesia services. This provision allowed hospitals to be paid on a cost basis, in addition to whatever PPS payments are made for an individual patient, for the services of CRNAs who are employed by or under contract with the hospital. This arrangement is due to

expire with hospital cost reporting periods beginning on or after October 1, 1987.

Under current law, the services of a CRNA are also recognized, for purposes of Medicare reimbursement, when the CRNA is employed by a physician. In this situation, the physician can bill, on a reasonable charge basis under Part B, as if he had actually performed the service. The CRNA's compensation in this instance is a matter between the CRNA and the employer.

Physicians are also able to receive payment, on a reasonable charge basis, when they provide medical direction to a CRNA employed by or under contract with a hospital. In this instance, the reasonable charge of the physician is reduced, from what it would have been had he performed the anesthesia service himself, to reflect the reduced level of his involvement and the fact that reimbursement for the CRNA is being made through the hospital.

The Committee bill authorizes direct payments, on a reasonable charge basis under Part B, for CRNA services. The bill would call for the Secretary to implement this provision in a manner that would not increase the total expenditures for CRNA and anesthesia services from what they would have been in the absence of this provision.

The Secretary would be required to set a limit on the prevailing charge screens for CRNA services. It is the Committee's expectation that the Secretary would use data from the present cost reimbursement made to hospitals to establish equivalent reasonable charge payments per procedure and would assume, for purposes of assuring budget neutrality, that all CRNA services would have been reimbursed on a cost basis. In paying for CRNA services under this provision, the Secretary may adopt the methodology currently used to pay for anesthesiology services, which involves "base units" assigned to each procedure and additional units for time intervals, or he may adopt some other method as appropriate to differentiate among services requiring different degrees of time, skill and risk. The Secretary may also make appropriate adjustments for changes in technology, trends in prices and cost-of-living, and variations in costs and charges among regions or carrier locales.

In addition to setting payments for CRNA services in a budget neutral manner, the Secretary would make adjustments in the payment of physician fees for medical direction of CRNAs, to the extent necessary to assure that total payments for anesthesia services are also budget neutral. For this purpose, the Secretary might reduce time units or base units, or derive some other method of adjustment. Because of concerns that reductions in the amount Medicare pays for medical direction might not be accompanied by commensurate reductions in the amount charged to patients on non-assigned claims, the bill would also place a limit on the amount that can be charged to a patient in situations where the Medicare payment has been reduced under this provision. The physician could charge the patient no more than 125% of the Medicare prevailing charge. These charges would be monitored and violations would be subject to sanctions by the Secretary.

In adopting this provision, the Committee does not intend to interfere with or override state law requirements regarding licensure or the practice of medicine or nursing. Nor does the Commit-

tee intend to interfere with requirements established by hospitals, consistent with state and Federal requirements, regarding the delivery of anesthesia services. The bill would not interfere with or mandate any employment relationships between CRNAs and others, nor would it dictate a single, uniform billing arrangement for CRNS services. Billing for such services could be done by an individual CRNA, by a group practice, or by a physician or hospital employer. The services of the CRNA and the medical direction of a physician could be billed together on one claim, so long as the services were clearly and separately identified and all other requirements of law were met.

Payment for physician services (Sec. 4525)

Under current law, Medicare pays for physician services on the basis of "reasonable charges", as determined under various Medicare rules and constraints. As a general matter, the reasonable charge is the lowest of (1) the physician's actual billed charge; (2) the physician's "customary charge" based on his actual charges during a prior base period; or (3) the prevailing charge screen, which is derived from the customary charges for all like physician services in the geographical area. Increases in the prevailing charge screen are limited by an economic index (the "MEI"), that is designed to reflect general inflation and changes in physician's office practice costs. At present, reasonable charges are in effect for a calendar year, and customary charges are based on actual charges during the July through June period preceding the start of the calendar year.

The Deficit Reduction Act of 1984 (P.L. 98-369) instituted a temporary freeze on Medicare reasonable charges, as well as a temporary freeze on the actual charges billed to patients. It also instituted a new program, called the participating physician program, which permits physicians to sign an agreement to take assignment, and accept the Medicare reasonable charge as payment in full, for all services furnished to Medicare enrollees. Nonfinancial incentives were provided to encourage physicians to sign such agreements.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) extended the temporary freeze with respect to nonparticipating physicians through the remainder of the calendar year 1986. It granted participating physicians an increase in prevailing charges equal to the MEI scheduled for 1986 (3.15 percent), plus an additional one percent. It also adopted other measures designed to improve the participating physician program. The current freeze on nonparticipating physicians is due to expire on December 31, 1986, under current law, but the participating physician program is a permanent feature of current law and the prevailing charge screen for nonparticipating physicians is designed to lag behind that for participating physicians by one year.

The Administration has indicated its intention to adjust the MEI increase that would otherwise go into effect on January 1, 1987. The purpose of the adjustment is to make a one-time correction for an error in the index, that occurred during the period between 1974 and 1985. HCFA's intended adjustment would result in an in-

crease in the prevailing charge screen, for both participating and nonparticipating physicians, estimated to be less than one percent.

The Committee does not agree with the Administration that this adjustment should be made. The MEI methodology has been revised, as of January 1, 1985, so the error has been corrected for future periods. The adjustment amounts to a virtual continuation of the freeze, which was originally intended to last but 15 months, but has since been extended to 22 months for participating physicians and 30 months for nonparticipating physicians. Moreover, the adjustment would undermine the participating physician program by failing to give those physicians any increase and by failing to place any constraint on a nonparticipating physician's actual charge billed to the patient.

The Committee bill would prohibit the Secretary from making the intended adjustment.

In order to avoid confusion in the future about the appropriate MEI increase for participating physicians, and make sure that participating physicians receive the full MEI increase scheduled for January 1, 1987, the bill would also clarify that the one percent additional increase granted to the prevailing charge screen for participating physicians last year is to be treated hereafter as a permanent, one-time addition to the cumulative MEI for participating physicians.

The practical effect of this provision, in combination with the provision in COBRA that the freeze on the prevailing charge screen for nonparticipating physicians is a permanent reduction in the cumulative MEI for nonparticipating physicians, is to create two separate cumulative Medicare Economic Indices—one for participating physicians and one for nonparticipating physicians. It is the Committee's intent that, in the absence of further action by the Congress, the lag between the prevailing charge screen for participating physicians and nonparticipating physicians instituted by COBRA be interpreted as calling for the same percentage increase in the MEI each year for these two groups, rather than giving nonparticipating physicians the same increase in one year that the participating physicians received in the prior year.

The bill would also adopt a differential increase in the prevailing charge screen, depending on whether the claim is made on an assigned basis, and would retain limits on the charges that can be billed by nonparticipating physicians. The purpose of these provisions is to provide incentives to become a participating physician and for nonparticipating physicians to accept assignment in individual cases. They are also designed to provide protections for Medicare enrollees against greater out-of-pocket expenses on non-assigned claims, and to restrain the increase in customary charges in later years.

Under the Committee bill, participating physicians would realize the full MEI percentage increase scheduled for January 1, 1987. This is estimated to be about 3.2 percent by the Congressional Budget Office. Nonparticipating physicians would also receive the full MEI increase on those claims for which they accept assignment. For those claims that are not accepted on assignment, nonparticipating physicians would receive only a 1% increase in the prevailing charge screen.

The limitation on actual charges billed by nonparticipating physicians would also differentiate between assigned claims and non-assigned claims. For assigned claims, the physician would be able to increase his actual charge over what he is now permitted to charge (which is his actual charges during the April-June quarter of 1984) by the same percentage as the MEI increase. For non-assigned claims, he would be able to increase his current actual charge by no more than 1%. The Medicare carriers would monitor these actual charges in the same manner as they have been doing during the current freeze, and the Secretary would sanction violations by civil money penalties or exclusion for the program.

These limitations on actual charges are adopted after extensive consideration of alternative proposals and the concerns expressed by an variety of interested parties. When the Congress adopted the provisions for the temporary freeze in July 1984, we did so in order to save Medicare expenditures, moderate the rapid increase in health care cost, provide financial protection to beneficiaries, and provide us time to review payment reforms. The extension of the freeze through 1986 was based on the same considerations. Unfortunately, we have not received the reports we requested from the Secretary on physician payment reform and the effects of the freeze, that were due on July 1, 1985, and we are not ready at this time to make reforms in payments for physician services.

If we did not take any further action at this time, we would be faced with a lapse of the current freeze provisions as of December 31, 1986, including a lapse of the protections afforded Medicare enrollees. This would not only place them at risk of substantial increases in charges billed on non-assigned claims, but would also increase the probability of their being billed through non-assigned claims, because of the financial disincentives to become a participating physician or take assignment.

The Committee believes that it is unacceptable to place Medicare beneficiaries in such a situation. At the same time, the Committee is unwilling to continue the existing freeze, which was always intended to be temporary. The bill reflects the Committee's efforts to accommodate these varying, and to some extent competing considerations. Once again, it is our intent that this be a temporary resolution of the issues and that we will be able to develop acceptable payment reform measures that obviate the need for these make-shift policies.

Guidelines for use of inherent reasonableness authority (Sec. 4526)

Section 9304 of the Consolidated Omnibus Budget Reconciliation Act of 1984 requires the Secretary to promulgate regulations setting forth criteria that will be used to determine that the standard reasonable charge rules have resulted in payments that are grossly excessive or deficient, and the criteria that will be used to adjust such charges into make them more reasonable. This provision was adopted in response to concerns expressed about the lack of such criteria and the manner in which such adjustments were being made by Medicare carriers, under the so-called "inherent reasonableness" authority stated in the current Medicare regulations.

Additional concerns have since been expressed about how the Secretary might attempt to use such authority to set national pay-

ment levels or national prevailing charge screens. Such concerns go to the manner in which the Secretary might develop such limitations and to the fact that there are no protections in current law against having Medicare payment reductions shifted to Medicare enrollees in the form of higher out-of-pocket expenses on non-assigned claims. The Secretary does not have authority under current law to reduce or limit actual charges, or to require that claims be submitted on an assigned basis.

In response to these concerns, the Committee bill would establish additional requirements that the Secretary must meet before changing a reasonable charge on the grounds that it is not inherently reasonable. The Secretary would have to follow the criteria established in the regulations mandated by COBRA. In addition, the Secretary would compare the charge in question with resource costs or charges for similar procedures, for the same procedure over time, or for the same procedure in different geographical areas, as well as comparing payment amounts allowed by other payors. If the Secretary sought to adjust for geographical differences that appeared to be grossly out of line with charges for the same service or procedure elsewhere in the country, the Secretary would have to take into account regional differences in the cost of furnishing the service.

Before making an adjustment, the Secretary would also be required to consider the effects of a change on such matters as quality, access, assignment rates, participation rates, and beneficiary liability. Before proceeding with a reasonable charge adjustment, the Secretary would also have to consult with the Physician Payment Review Commission, publish a notice of the proposed adjustment in the Federal Register, and allow for public comment.

The bill would also provide for protections against increases in the Medicare enrollee's liability on non-assigned claims. Whenever the Secretary exercised the authority in this section to reduce the Medicare reasonable charge, a limit would be placed on the maximum amount that the physician could bill the patient. That limit would be 125% of the prevailing charge for that service, as adjusted downward by the Secretary under this provision. A physician who charged in excess of this amount would be required to refund the excess amount to the patient, and a physician who knowingly and willfully billed charges in excess of this amount or refused to make a refund could be subject to civil money penalties or exclusion from the program. A limitation on actual charges was selected, in lieu of requiring assignment on all claims for which Medicare charges are reduced, in an effort to balance concerns about the beneficiaries' liability with concerns about the effects that requiring assignment on all claims might have on access and quality.

Payment for cataract surgical procedures (Sec. 4527)

Cataract surgery is a procedure that has been undergoing rapid changes and improvements in techniques and technology. These have enhanced both access and quality. Cataract surgery is now the most common and most rapidly growing surgical procedure covered by Medicare, with over one million procedures performed on Medicare enrollees in 1985. It is also a procedure that is performed predominantly on Medicare enrollees, with Medicare patients rep-

representing over 80% of all cataract surgeries. Thus, practices and payment levels are not as strongly influenced by the non-Medicare patient community as is the case with most other procedures.

The Health Care Financing Administration has conducted extensive research and analysis on the practices and reasonable charge levels involved in cataract surgery and the anesthesia services furnished during cataract surgery. The HHS Inspector General has also conducted a study on Medicare reimbursement for anesthesia services furnished during cataract surgery. In testimony before the Subcommittee on Health and Environment, HCFA advised that it has concluded that the normal application of the Medicare reasonable charge methodology has resulted in payments that are currently far in excess of those warranted by the degree of time, resources, and expertise demanded of the physician or those needed to assure access and quality of care. HCFA further testified that, on the basis of its analysis, it intends to reduce the reasonable charges for these services.

The Committee has reviewed the information, analysis and conclusions made available to it by HCFA and is persuaded that some reduction in Medicare payments is warranted for these particular services. However, the Committee is concerned that reductions in Medicare payments could result in substantially higher payments by Medicare enrollees on non-assigned claims, if physicians do not make comparable adjustments in their actual charges. HCFA does not currently have authority to protect Medicare enrollees against such increases, through requiring that claims be filed on an assigned basis, through reductions in the actual charge, or by other means.

The Committee bill would require the Secretary to reduce Medicare reasonable charges for these services, but would add a provision limiting the maximum amount that could be charged to a Medicare enrollee.

The first reduction would be in the payment for cataract surgery when an intraocular lens is implanted. Implantation of a lens is now the preferred procedure among physicians and patients and it is performed in over 80% of cases. It is now a relatively quick procedure, but it does require skill and expertise beyond that needed for removal of the cataract alone. When a lens is not implanted, it is typically because the patient presents problems or complications that indicate a lens implantation is not appropriate. These same conditions or complications typically mean that the cataract removal procedure is more difficult and time-consuming than would be the case with a patient who was a candidate for lens implantation. This helps to explain why HCFA found that there was virtually no time differential, on average, between cases with lens implantation and cases without lens implantation.

The current Medicare reasonable charge levels for cataract surgery are based on historical practices and charge levels, and reflect the fact that at one point cataract removal and lens implantation were two distinct procedures typically performed at different times. The current reasonable charges for the procedure with lens implantation reflect the reasonable charges for the two procedures when done separately. In its testimony before the Subcommittee, HCFA indicate that there is a differential of approximately 55%

between the prevailing charge for lens extraction without an IOL and lens extraction with an IOL.

The Committee recognizes that some differential in payment is warranted when a lens is implanted, to reflect the additional skill and expertise involved. However, the Committee concludes that changes in technology and medical practice have resulted in the charges for this procedure being excessive. Moreover, it is the Committee's understanding that the current charges for cataract removal without lens implantation is not viewed as inadequate, even though it typically involves a more difficult procedure than cataract removal itself when a lens is implanted. The Committee concludes that it is appropriate to take this into consideration in determining an appropriate differential in payment when a lens is implanted. Based on HCFA's analysis and these considerations, the bill would set an upper limit on the prevailing charge for cataract removal with lens implantation of 110% of the prevailing charge for cataract removal without lens implantation.

Anesthesia services during cataract surgery have also undergone significant changes over the last few years, so as to improve the safety, quality and cost-effectiveness of such services. The current Medicare reasonable charges for these services, however, do not reflect these changes.

Payments for anesthesia services are based on a unique system that combines base units, which are set according to the difficulty, risk and other factors involved in the procedure, with time interval units, which reflect the amount of time devoted to the service. These base and time units are then multiplied by a dollar conversion factor to determine the reasonable charge for each physician.

According to HCFA, the number of base units attributable to anesthesia services during cataract surgery is typically eight. This reflects the level set when cataract surgery was done predominantly as an inpatient service and the patient was given general anesthesia. Today, most cataract surgery is done on an ambulatory basis in a hospital outpatient department or a free-standing ambulatory surgical facility. Often, the patient is given local anesthesia and the anesthesia is administered by the surgeon rather than an anesthesiologist or other physician. For most of the procedures which are covered by Medicare when done on an ambulatory basis, the number of assigned base units is three; virtually all of them are assigned base units of three or four. Some carriers have reduced the level of payment for anesthesia services during cataract surgery, with no apparent effect on quality or access. Based on its analysis of this information, changes in technology and practice, and the study by the Inspector General, HCFA has concluded that payments for anesthesia services during cataract surgery are greater than warranted and greater than needed to assure access and quality.

Based on his review of these issues, the Inspector General recommended that payments for what he referred to as "monitored anesthesia" should be reduced to time units only, or to time units plus no more than three base units. The Committee is advised that HCFA is reviewing a proposal to reduce the base units for all anesthesia services during cataract surgery to four. The Committee con-

curs in HCFA's findings and resolution, and the Committee bill requires a reduction in the base units to four.

Because of the Committee's concern that reductions in Medicare payments might result in substantial increases in the out-of-pocket expenses of Medicare patients on non-assigned claims, the bill would also include a limitation on actual charges billed patients on non-assigned claims. The provision included in this section is the same as that included in other sections of the bill dealing with reductions in Medicare reasonable charges. Physicians could not bill patients in excess of 125% of the Medicare prevailing charge, as adjusted under this provision.

Clinical diagnostic laboratory services (Sec. 4528)

Section 2303 of the Deficit Reduction Act of 1984 restructured the method used by Medicare to pay for diagnostic clinical laboratory services furnished to ambulatory patients. Under that provision, statewide or carrier-wide fee schedules were established, effective July 1, 1984, based on a percentage of the prevailing fees that would have been in effect on that date.

At the time this provision was adopted, questions were raised whether hospital laboratories should be treated differently than independent laboratories, because they might need to have special equipment, to remain available more hours, or to respond more quickly, in order to meet the needs of their outpatient and emergency room patients. In response, section 2303 set the fee schedules for hospital laboratories, when serving outpatients of the hospital, at 2 percentage points higher than the fee schedules for independent laboratories. Section 2303 also provided that the fee schedules would expire for such services on June 30, 1987, and payment for such services would revert to a cost-based system. The date of this expiration was changed to December 31, 1988, by the Consolidated Omnibus Budget Reconciliation Act of 1985.

The Committee bill would conform hospital laboratory fee schedules to those for independent laboratories, by removing the 2 percent differential and eliminating the expiration of fee schedules for hospital laboratories. The Committee believes that this change will not have an adverse effect of access or quality under the existing fee schedules and notes that a study by the Comptroller General is due on January 1, 1987, which will include an examination of the potential impact on hospital laboratories of a national fee schedule.

The Deficit Reduction Act also provided that a national fee schedule would be instituted on July 1, 1987. The date of implementation was moved to January 1, 1988 by COBRA. The Committee bill would remove the deadline for this requirement, in view of the upper limits placed on the current fee schedules by section 9303 of COBRA. The Committee will review this issue again, after receiving the report of the Comptroller General on the anticipated effects of a national fee schedule.

The bill would also authorize payments to cover the transportation and personnel expenses of sending trained personnel to collect a specimen, by such means as venipuncture or catheterization, from a patient who is unable to travel from home or a nursing home to a physician's office or laboratory. The provision in DEFRA included payment of a nominal fee for the collection of such speci-

mens. The intent of that provision was to pay for the actual drawing of the specimen, not for the expenses of going to the home of a patient in order to do so. The conference agreement for DEFRA stated explicitly that this provision was not intended to make any change in existing payment practices regarding trip fees. However, the Committee has been informed that there is confusion on this issue and that some carriers are now denying payment for trip fees that were previously paid. The payment of such fees seems to be a reasonable and appropriate cost in the provision of needed health care.

The bill would also allow laboratories to qualify for Medicare reimbursement if they meet state licensure or practice laws regarding the qualifications of the director of the laboratory. Medicare regulations currently require that, with some limited exceptions, the director of a laboratory must be a physician or a person holding a doctorate degree. Some states, however, permit laboratories to provide services in the state if the director of the laboratory has a master's degree and meets other qualifications. It is standard practice in the Medicare program to rely on state licensure and practice laws to assure that persons or providers are qualified to provide the care in question. It seems appropriate to do so in this instance, as well. This would preclude the Secretary from denying Medicare payments to a laboratory, on the grounds that the director does not meet the requirements currently set forth in the Medicare regulations, if the laboratory director met the requirements of state law. It is not the Committee's intention that the Secretary deny Medicare payments to a laboratory that does meet the current requirements in the regulations, on the grounds that state law requires a different standard.

Payment for parenteral and enteral nutrition (Sec. 4529)

Parenteral and enteral nutrition is a technology that has undergone rapid expansion in recent years. It saves lives and enhances quality of care, and it can do so in a cost-effective way by permitting patients to be discharged from institutions and receive the service at home. Because of its rapid expansion, however, questions have been raised whether the reasonable charges allowed by Medicare, which are based on historical charging patterns, are excessively high and could be reduced without impairing access or quality.

The Medicare carriers have collected data indicating that there are wide variations in the charges for these services. These data also show that, in many cases, the Medicare payments are excessive, compared to the charges for similar services and supplies that are readily available. HCFA has been reviewing a proposal to reduce the variations and the overall levels of payments, using the authority under current regulations to make adjustments for charges that are not inherently reasonable. Serious concerns have been raised about the data and analysis being used by the carriers and HCFA. Moreover, the project has been delayed because of the Secretary's obligation to comply with the provisions of section 9304 of the Consolidated Omnibus Budget Reconciliation Act of 1985. That section requires the Secretary to publish regulations setting

forth the criteria by which a charge will be determined not to be inherently reasonable and the criteria by which it will be adjusted.

The Committee bill would require that the Secretary apply the "lowest charge level" provision in current law. This provision authorizes the Secretary to pay for services, supplies and equipment, that he determines do not generally vary significantly in quality from one supplier to another, at the lowest charge levels at which such services, supplies and equipment are widely and consistently available. The regulations implementing this provision establish such lowest charge levels at the 25th percentile of the charges submitted for the item or service in question.

The Committee believes that parenteral and enteral nutrition supplies and equipment are an appropriate candidate for application of the lowest charge provision. There are many suppliers in the market, supplying similar products. Many of these suppliers are regional or national in their scope of operation. Geographical variations in reasonable charges that result from historical charge patterns, and wide differentials in generally equivalent products, do not appear to be warranted.

HCFA has consolidated the payment of claims for these services in two carriers. It is the Committee's expectation that HCFA will apply the lowest charge level on either a national basis or within each of the two areas served by these carriers, but that exceptions can be made to meet unusual circumstances. It is also the Committee's expectation that, in setting lowest charge levels, the Secretary will endeavor to compare like products—products that are equivalent in meeting the nutritional needs of the patient and products of comparable quality—rather than looking solely at the volume of nutrients in a particular container or comparing items that are dissimilar in function or quality. All the available charges submitted for such services should be used in calculating the lowest charge level. The Secretary should be sensitive to special patient needs or special circumstances and should provide for exceptions to the standard charges computed under this provision, when appropriate.

The Committee's bill would not reduce the payment for these services as much as would be the case under the proposal being that HCFA currently has under review. The bill would preclude HCFA from proceeding such a proposal at this time.

Payment for oxygen therapy services (Sec. 4530)

Under current law, oxygen therapy services provided in the home under Medicare are reimbursed on a reasonable charge basis. The Committee heard testimony that, since Medicare will pay for whatever amount of oxygen is used by a patient, the current system does not contain any incentives for patients and suppliers to use the most efficient system and this leads to a wastage of oxygen and money.

Under the Committee bill, the Secretary would be required to develop a prospectively determined, monthly capitation fee schedule for oxygen therapy in the home. The Secretary would have discretion to determine whether the fee schedule should be on a regional, statewide, or carrier service area basis. The payment would be made on the basis of the number of units of oxygen prescribed for a patient per month, without adjustment for the actual number of

units used. Thus, the payment amount would vary in accord with the amount prescribed by the physician.

The monthly capitation amounts would be determined on the basis of the reasonable charges determined under Medicare, during the twelve-month base period ending June 30, 1986, for consumable oxygen. In determining the monthly capitation amount, the Secretary would exclude charges during the base period relating to the purchase or rental of equipment. The payment amount under Medicare would equal 80% of the monthly capitation amount, with the patient being responsible for the normal 20% coinsurance. The amount paid under this provision would cover all services, equipment and supplies, as well as consumable oxygen, needed by the patient. There would be no additional payment for equipment and supplies, whether furnished on a rental, purchase, or lease-purchase arrangement.

The Secretary would also be required to provide for a minimum monthly amount for oxygen therapy in order to assure the availability of oxygen therapy services for beneficiaries requiring only small amounts of oxygen.

In no case would payment be made for oxygen therapy services prescribed by a physician who had a significant ownership interest or financial or contractual relationship with the organization providing the oxygen therapy services. The Committee recognizes that this could result in access problems in communities with a sole supplier of such services. In such cases, the Secretary would have the authority to grant an exception to this provision.

The Committee provision would also require the Secretary to pay bills for oxygen services promptly. The Committee expects that claims will be paid within 22 days, and provides for interest penalties for failure to make prompt payments.

The Secretary would be required to report to the Congress on the implementation and effects of these provisions by July 1, 1988. The Committee intends the Secretary's report to assess the effect of these changes on patient outcomes, the availability of oxygen therapy services to medicare beneficiaries, and changes in oxygen therapy technology.

*Additional members for Physician Payment Review Commission
(Sec. 4531)*

The Consolidated Omnibus Budget Reconciliation Act of 1986 established a Physician Payment Review Commission of 11 members to make recommendations regarding Medicare payments for physician services. Members are appointed by the Director of the Congressional Office of Technology Assessment.

The Committee provision would add 2 Members to the Commission, increasing the size from 11 to 13 Members. The Committee action is in response to concerns that the Commission did not adequately represent the variety of interested and affected parties, particularly rural interests. The Director of the Office of Technology Assessment would appoint the two new members within 60 days of enactment of this Act.

Part B appeals (Sec. 4532)

Under current law, if an individual disagrees with a decision regarding his or her eligibility for Medicare, the individual is given the opportunity for an appeal to an administrative law judge ("ALJ") and to judicial review of the ALJ's decision. Similarly, if a beneficiary disagrees with a denial, in whole or in part, of a claim submitted under Part A of Medicare, he or she is entitled to a hearing before an administrative law judge, if the amount in controversy is \$100 or more. The beneficiary also can seek judicial review of the ALJ's decision, if the amount in controversy is \$1000 or more. Similar appeal rights are not available, however, to a beneficiary with respect to claims under Part B of Medicare.

If a beneficiary disagrees with a denial of a claim under Part B, he or she can only obtain a reconsideration by the carrier which denied the claim and, if the amount in controversy is \$100 or more, a review by a hearing officer appointed by the carrier which denied the claim. There is no judicial review of the hearing officer's decision.

Part B claims were not accorded the same appeal rights as Part A claims at the inception of the Medicare program, because Part B claims were expected to be for substantially smaller amounts than claims under Part A. In addition, Part B claims are far more numerous than Part A claims and could present a substantial workload if judicial review were accorded to all of them. Today, however, Part B claims often involve very substantial amounts and, if denied, entail large out-of-pocket expense for the beneficiary.

Numerous concerns have been expressed by beneficiaries about the fairness and adequacy of this Part B appeals process. Some have expressed the concern that the hearing officers are not properly qualified or are not objective, because many of them are former employees of the carrier or because their continued service as hearing officers may depend on the carriers' being satisfied with the decisions they render. Other concerns deal with the way hearings are conducted, including the beneficiaries' inability to produce evidence or to challenge the hearing officers' decision rules or his reliance on unidentified experts and consultants.

The Committee bill would attempt to resolve these concerns by establishing an appeals procedure under Part B that is modeled after that available under Part A. Review by an ALJ would be available if the amount in controversy were \$500 or more and judicial review would be available if the amount in controversy were \$1000 or more.

Hearings under Part A are, in most instances, assigned to administrative law judges working in the Office of Hearings and Appeals of the Social Security Administration. Medicare appeals are very different from the social security complaints they typically hear and may represent a very small and infrequent portion of their workload. Therefore, these ALJ's may not develop the experience and expertise in Medicare appeals that they would if they devoted full-time to those appeals. With the additional workload that would be established under the bill, it is the Committee's expectation that the Department of Health and Human Services will give serious attention to establishing a separate office of hearings and appeals for

the Health Care Financing Administration or otherwise creating a group of hearing officers devoted exclusively or predominately to Medicare appeals.

Alzheimer's disease demonstration projects (Sec. 4533)

Medicare beneficiaries with Alzheimer's disease or related disorders are covered for acute Medicare care services, including hospital care and physician services. However, these beneficiaries often require additional services, such as adult day care, counseling, respite care, and home and communitybased services, to maintain functioning and remain in their own homes. These services are not generally available under Medicare.

The Subcommittee held a hearing in January 1986 in Palm Harbor, Florida on Alzheimer's disease and related disorders. Each of the witnesses who appeared before the Subcommittee stressed the need for financing for alternative services in the community to allow families to keep their loved ones at home instead of having to seek care in a nursing home. The testimony presented also made it clear that there is a need to learn much more about what services are most effective and what it will cost to provide needed care.

Under the Committee bill, the Secretary of Health and Human Services would be required to fund at least five demonstrations to determine whether to include additional services for Alzheimer's disease and related disorder patients as a Medicare benefit. These projects would address the criteria for determining who is eligible for services as an Alzheimer's disease patient, the range of services needed, the cost of care for such patients, and the impact of such services on the health status and functioning of the patients.

The Committee bill would require that each of the five demonstration projects be put into place for a period of three years at a total funding level of \$40 million for the cost of expanded services. An additional \$2 million would be provided to fund an independent evaluation of the demonstration.

Under the demonstration, each site would receive approximately \$2.5 million per year to fund expanded services for approximately 500 beneficiaries with Alzheimer's disease. The expanded services that should be provided by each project include case management services, outpatient drug therapy, home and community-based care, adult day care, and respite care and other supportive services and counseling for the family. The Committee is interested in learning which of these services is most effective in providing assistance to allow Alzheimer's patients to be maintained in their own homes and in the community. The Committee is therefore interested in assessing the cost and impact of supportive services, counseling, and respite care for the family, as well as direct services to the Alzheimer's patient.

The Committee is also interested in learning more about the diagnosis of individuals with Alzheimer's disease and the relationship between level of impairment and service needs. Accordingly, under the Committee bill, all participants in the Alzheimer's demonstration projects must receive a comprehensive medical and mental status evaluation upon entering the demonstration and prior to discharge. This comprehensive evaluation should include standard mental-status tests such as the information orientation

concentration test, the minie mental status test, and the Dementia Rating Scale. In addition to the mental-status testing, the comprehensive evaluation should include a complete history; physical, psychiatric, and neurologic examination; and laboratory services. Any component of the evaluation that is not currently covered by Medicare is to be covered by the service dollars that would be made available under this bill.

In choosing sites for this demonstration, the Committee intends the Secretary to select geographically diverse areas with a significant number of Medicare beneficiaries living in the surrounding locality. Since participation in the demonstration is limited to those individuals currently eligible for Medicare, sites should be selected to assure that there are sufficient Medicare beneficiaries with Alzheimer's disease to achieve the goal of 500 project participants.

The Committee bill would require the Secretary to conduct an independent evaluation of the cost and effectiveness of the services provided under these demonstration projects. The Committee expects the evaluation to address the appropriateness of using the comprehensive medical and mental status evaluation as an eligibility screen to qualify patients with Alzheimer's disease and related disorders for receipt of expanded services.

The bill would require the Secretary to submit a report to Congress within 3 years, describing the projects in progress. After completion of the demonstration, the Secretary would also be required to submit a final report that evaluates the costs and benefits of providing expanded Medicare services and includes recommendations for appropriate legislative change.

The provisions would be effective on October 1, 1986.

Delays in processing Medicare claims

The Committee notes its concern about the delays taking place in the processing of Medicare claims by fiscal intermediaries and carriers, and the adverse effects this is having on patients and providers.

Prior to this year, claims were generally being processed within reasonable time frames and providers were able to manage their operations with some assurance that payment would be forthcoming. During the last several months, however, Medicare contractors have been instructed to delay deliberately in processing claims and paying bills. Extensive backlogs have developed. Both patients and providers have been adversely affected, and there is a growing discontent with the program. Home health agencies, which typically have modest working capital, have been particularly affected by this policy.

The Health Care Financing Administration first instituted the slowdown in payments on the grounds that reductions in the administrative budget under the Gramm-Rudman deficit reduction act left the contractors without sufficient funds to continue processing claims within their prior timeframes. However, in testimony before the Subcommittee on Health of the Committee on Ways and Means, on April 22, 1986, HCFA revealed that the policy of deliberate delay was viewed favorably by the Administration, irrespective of the Gramm-Rudman reductions, because it resulted in greater

interest revenues for the trust fund. This is a highly inappropriate and objectionable policy.

Fiscal intermediaries and contractors, that were previously evaluated, in part, on the basis of whether they could process claims faster than specified benchmarks, have now been advised that their evaluations will be downgraded if they process claims more quickly than the new, delayed benchmarks.

The Committee intends to support measures to rectify this situation. Backlogs must be reduced, provider and beneficiary services restored, and processing times returned to their historical patterns and to practices common in the health insurance industry.

PROVISIONS RELATING TO MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

SUBTITLE G—MEDICAID AND MATERNAL AND CHILD HEALTH

Optional coverage for poor pregnant women and infants (Sec. 4601)

Under current law, States must provide Medicaid coverage to, among others, all pregnant women and all infants up to age 1 who meet the income and resource requirements under their State's Aid to Families with Dependent Children (AFDC) program. With respect to eligible pregnant women and infants, States must offer the same amount, duration, and scope of benefits as they offer to other mandatory-eligible groups. This requirement applies regardless of the family composition of either the pregnant woman or infant, and regardless of whether the woman or infant is receiving cash assistance under the AFDC program. States also have the option of extending coverage to pregnant women and children whose family income or resources exceed AFDC eligibility levels but who are unable to pay for needed medical care. These individuals, known as the "medically needy," qualify by incurring high medical expenses which, when applied against their incomes, bring their incomes down below the State's medically needy income level.

In November, 1985, the Southern Governor's Regional Task Force on Infant Mortality issued its final report, "For the Children of Tomorrow." The Task Force found that one out of four babies born to mothers receiving little or no prenatal care are born low birthweight. These babies are forty times more likely to die in the first year than babies who weigh more, and four times more likely to be hospitalized at birth. The Task Force concluded that the availability of prenatal care can make a significant difference in reducing these risks. In Georgia, for example, women who receive prenatal care are six times more likely to deliver a baby of normal birthweight than women who receive inadequate or no prenatal care. The Task Force also documented the savings that can result from early prenatal care, finding that between \$2 and \$10 can be saved in medical care costs for every dollar spent.

These conclusions confirm the findings of the study issued by the Institute of Medicine in 1985, "Preventing Low Birthweight." In testimony before the Subcommittee on Health and the Environment, the IOM study group concluded that each dollar spent on prenatal care could save over three dollars in reduced health care costs for the care of low birthweight infants. Other studies which

have examined the cost-effectiveness of prenatal care for Medicaid beneficiaries have documented savings of at least \$2 in health care costs for every dollar spent on prenatal care.

The Medicaid program has not been as effective as it should be in assuring access by prenatal care by high-risk, low-income pregnant women. A major reason is the linkage between Medicaid eligibility and AFDC payment standards. Currently, unless a State offers coverage to the "medically needy," a pregnant woman whose income or resources exceed those of her State's AFDC program cannot qualify for Medicaid. In many States, AFDC payment standards—i.e., in most States the amounts which an individual's countable income cannot exceed if she and her family are to remain eligible for benefits—are extraordinarily low. Information provided by the Congressional Research Service indicates that, as of January, 1986, the AFDC payment standards for a family of three ranged from \$118 per month, or 15.5% of poverty, in Alabama, to \$693 per month, or 91% of poverty, in Utah. Of the 51 States and jurisdictions, 12 States have set their AFDC payment standard at 60% of poverty or above; 20 States have set their standard between 40% and 60% of poverty; and 19 States have set their standard below 40% of poverty.

As a result, many families who are clearly poor and cannot afford needed medical care are nonetheless ineligible for Medicaid. Even in States that cover the "medically needy," health care providers must often be willing to furnish a substantial amount of health care services on a credit or charity basis until the individual has incurred sufficiently large medical bills to reduce her family income below the State's "medically needy" eligibility levels, which cannot exceed 133 percent of the State's AFDC payment levels. The Committee is informed that, in many States, few providers are willing to provide large amounts of uncompensated care, especially for pregnancy-related services to high-risk women. Instead, providers generally expect that payment for these services (including payment for hospital services) will be made prior to the delivery of the baby if the woman is not insured. As a result, thousands of poor pregnant women go without cost-effective care during pregnancy and thus, are at greater risk of bearing low birthweight infants, who are in turn at greater risk of dying within their first year of life or developing disabilities that will subsequently qualify them for Medicaid coverage.

The Southern Governors' Task Force made a number of recommendations regarding the delivery and financing of maternal and child health services designed to reduce infant mortality rates. One of these recommendations—that the Federal government amend the Medicaid law to permit States to provide Medicaid assistance to poor families whose incomes are over the States' AFDC standard of need—was subsequently adopted as a legislative priority by the National Governors' Association. Specifically, the Governors want an option that enables them to finance prenatal and infant care for low-income families under Medicaid without raising AFDC payment standards or adopting a "medically needy" program.

Based on this recommendation, the Committee bill would create a new optional categorically needy group composed of pregnant women and infants up to age 1 with family incomes of up to the

Federal poverty level (\$760 per month for a family of 3 in 1986). States could choose whether or not to cover this group and, if so, at what level (between its AFDC payment level and 100 percent of the Federal poverty line) to set the income eligibility threshold. However, if a State chose to extend such coverage, it could not reduce its AFDC payment levels below the levels that were in effect as of April 17, 1986. Moreover, it would have to cover both the pregnant women and the infants up to age 1, and would have to set the income threshold at the same percentage of poverty for both pregnant women and infants, and for all family sizes.

States could exercise the option to cover this group whether or not they also offer coverage to the "medically needy." Unlike "medically needy" beneficiaries, however, this optional categorically needy group cannot qualify for Medicaid coverage by "spending down," or incurring large medical expenses. Instead, pregnant women and infants must have family incomes below the State-established levels in order to qualify for this optional coverage; the size of their medical expenses is not relevant. However, where a State chooses to cover both the "medically needy" and this new optional categorically needy group, the State could not require those pregnant women and infants that meet the new income test to "spend down" to a lower "medically needy" income level.

In determining either a pregnant woman or infant's income, the State would be required to use the same budgeting methodology that is used in determining a family's eligibility for AFDC benefits. Furthermore, in determining a pregnant woman's family income level, the Committee intends that a State would treat the woman as if her child were born and living with her at the time she applied for assistance. Thus, a single woman would be treated as a family of two, a pregnant woman living with a spouse or child as a family of three, and so forth.

Under the Committee bill, coverage for pregnant women would begin as soon as the pregnancy is medically verified and would continue for 60 days following the last day of pregnancy. Frequently, a pregnant woman's countable family income will change during the course of her pregnancy. This may happen either because a family member works a few additional hours or because the AFDC program's earned income disregards (which are used to calculate a family's countable income) expire, leaving the family with no additional real income but with more countable income. This slight change in countable income can disqualify a pregnant woman from Medicaid coverage in the middle of her pregnancy. Without Medicaid coverage, however, she may be unable to receive any prenatal care.

It is the Committee's understanding that the interruption of Medicaid benefits during pregnancy is a common occurrence in many States. It is also the Committee's understanding that prenatal care is most effective when it is received periodically and continuously throughout pregnancy. The Committee bill would, therefore, permit a State to treat a pregnant woman eligible for Medicaid under this new optional group as eligible for Medicaid throughout her pregnancy and post-partum period without regard to any change in her family income level. In effect, this option would permit States to guarantee a minimum Medicaid enrollment period

for pregnant women that covers both the pregnancy and the post-partum period.

The Committee bill would require States to extend coverage for infants until age one. However, if the infant were an inpatient on its first birthday in either a hospital or a long-term care facility, coverage would have to be extended until the end of the infant's inpatient stay.

In order to ensure that low-income pregnant women with modest family resource levels are not denied coverage under this new optional program, the Committee bill would prohibit States from considering a pregnant woman's family resources (as defined under the AFDC or SSI programs) in determining her eligibility. In view of the compelling evidence for the effectiveness of prenatal care in reducing infant mortality, the Committee is particularly concerned that Medicaid coverage for pregnant women begin as soon as possible. However, restrictive AFDC resource tests (\$1,000 per family, including a home and a car with an equity value of \$1,500) often make this goal impossible. Such tests frequently result in the exclusion of self-employed families that own a truck or working equipment. A pregnant woman in such a family is then forced to either sell off her family's sole source of earnings in order to raise funds to pay for prenatal care or to forego such care entirely. In the view of the Committee, it would be irrational from the standpoint of public health policy to require poor pregnant women to make such a choice. It would defeat both the goal of ensuring family self-sufficiency and the goal of increasing access to early and adequate prenatal care.

With respect to infants, States would not be able to apply a resource standard or methodology that is more restrictive than that used under their AFDC programs. States, would be able, however, to elect to use the SSI resource standards for infants, some other less restrictive resource test, or to improve no resource requirement at all.

The infants covered under the Committee bill would be entitled to the same amount, duration, and scope of benefits provided to the categorically needy—e.g., AFDC cash assistance recipients—under a State Medicaid plan. The covered pregnant women, however, would be entitled only to coverage for services related to pregnancy. Such services include prenatal, delivery, and post-partum care as well as services required for conditions which may complicate the pregnancy.

Federal Medicaid matching funds would be available for this optional group for expenditures made on or after July 1, 1987.

It has come to the attention of the Committee that, in determining whether a "medically needy" pregnant woman has incurred sufficient medical expenses to reduce her family income below the State-established income levels, HCFA has verbally instructed the States that payments demanded by providers in advance of services rendered may not be treated as incurred expenses. It is evidently HCFA's position that no expenses can be "incurred" until services have been actually provided.

In the view of the Committee, this interpretation of the term "incurred" is inconsistent with the Medicaid statute and is contrary to prevailing obstetrical, hospital, and medical billing practices. The

effect of HCFA's interpretation is to prohibit "medically needy" pregnant women from either registering in advance of hospital delivery or arranging with a physician for delivery services. Obstetricians and hospitals commonly will not provide care on credit. Indeed, the Committee is informed that prepayment requirements for pregnant women in some localities are as high as \$3,000.

The Committee believes that the only reasonable interpretation is that a pregnant woman "incurs" a medical expense as soon as she is given a bill for her care. If a hospital or physician requires payment in advance of providing care, the woman is obligated to pay before services are rendered. Therefore, she may present this bill to the State in order to establish Medicaid "medically needy" eligibility, even though the State will not pay the bill until the service is actually received. This interpretation will promote a basic purpose of the Medicaid statute by removing a financial barrier to access to early prenatal care by low-income women.

Optional coverage of elderly and disabled poor for all Medicaid benefits (Sec. 4602)

Under current law, Medicaid coverage is generally not available to a poor elderly or disabled individual unless he or she is receiving cash assistance under the Supplemental Security Income (SSI) program, is living in a nursing home, or has very high recurring medical expenses. The maximum countable income for eligibility for Federal SSI benefits in 1986 is \$356 per month for an individual, or 76 percent of the Federal poverty level, and \$524 per month for a couple, or 90 percent of poverty. In about half the States, the income level for eligibility is somewhat higher because the State supplements the Federal SSI benefit payment. In about 30 states, elderly and disabled poor who are not receiving SSI or State supplementary cash assistance qualify for Medicaid under "medically needy" coverage or under special provisions allowing coverage of individuals in nursing homes.

For those elderly and disabled who are eligible, Medicaid supplements Medicare coverage by filling in the gaps left by Medicare's cost-sharing requirements and by providing additional benefits to complement Medicare's coverage of acute care. Medicaid pays the Medicare Part B premium as well as the Part A and B cost-sharing and deductibles for Medicare beneficiaries. Medicaid also covers services not covered by Medicare, including prescription drugs, dental care, and nursing home care. States receive Federal matching payments for their Medicaid expenditures for this population. However, in the case of the "medically needy," States do not receive Federal Medicaid matching funds for expenditures for the Medicare Part B premiums of this group.

In the view of the Committee, extension of Medicaid coverage to poor elderly and disabled Medicare beneficiaries is a pressing priority. On March 26, 1986, the Subcommittee on Health and the Environment heard testimony from the Congressional Budget Office testified that 20 percent of our senior citizens—5 million people—are without Medicaid or private insurance to supplement their Medicare benefits. These beneficiaries, relying on Medicare alone to finance needed health services, are among the sickest and poorest of our senior and disabled citizens. They face substantial out-of-pocket

costs for needed care and can incur devastating financial burdens when illness strikes.

The Committee observes that Medicare covers less than half of the health expenses of the elderly and disabled and require substantial cost-sharing. In 1986, Medicare beneficiaries will pay \$186 for premiums for part B coverage, a \$492 deductible for the first day of hospital care, and a physician deductible of \$75 plus 20 percent cost sharing on all claims and extra billing if the physician does not take assignment. Medicare also does not cover many services that the elderly and disabled need, such as prescription drugs, dental care, extended nursing home care, or other long-term care services. As a result, out-of-pocket expenses for an elderly person with a moderate spell of illness can easily exceed \$2,000. The Committee notes that this is a major expense for anyone, but a devastating financial burden for the nearly 4 million elderly poor struggling to live on incomes of less than \$5,000 per year.

Medicaid provides protection for the poor who lack the ability to pay out-of-pocket for health services or purchase private supplemental insurance coverage. The Committee observes, however, that Medicaid does not reach all low-income elderly and disabled. Only 36 percent of the elderly with incomes below the Federal poverty line receive benefits from Medicaid today. An estimated 2.2 million elderly individuals with incomes below 100 percent of the Federal poverty level (\$4,979 in 1984) are not covered.

It is precisely those without Medicaid or private supplemental coverage that have the greatest health needs and the lowest use of services. CBO testified that the elderly without Medicaid or supplementary private insurance were both older and sicker than other Medicare beneficiaries. Yet, despite their greater health needs, these individuals do not receive care at rates comparable to others. Those elderly with Medicare coverage only are 13 percent more likely to have fair or poor health than those with both Medicare and supplementary insurance, but they receive 35 percent fewer physician visits per capita, 25 percent fewer prescription drugs, and are 18 percent less likely to be admitted to a hospital.

The Committee believes it imperative to protect the poor elderly and disabled from the financial burdens of illness. The Committee bill therefore allows States, at their option, to extend Medicaid coverage to elderly and disabled individuals whose incomes is up to 100 percent of the Federal poverty guidelines (\$477 per month for an individual and \$603 for a couple). States could decide whether to extend coverage to this new "optional categorically needy" group and, if so, at what level to set the income eligibility threshold. However, if a State elected this option, it would have to cover both the elderly and the disabled, and would have to apply the same income standard and resource test to both groups and to all family sizes. In addition, if a State elects to cover some elderly and disabled under this option, it must also extend coverage to some pregnant women and infants up to age 1 in the optional categorically needy group created by section 4601 of the Committee bill.

The Committee bill uses as the upper bound for income eligibility for this optional group the non-farm official poverty line as defined by the Office of Management and Budget and revised annually. This level is adjusted for family size, but does not differentiate

between the income needs of the elderly and non-elderly. The Committee has selected this measure of poverty status because it feels that it is appropriate to use the same measure of poverty for the elderly and non-elderly for purposes of Medicaid eligibility. Since the OMB poverty level is revised annually to adjust for inflation, States will have the opportunity to increase the eligibility standard to keep pace with inflation and the resultant changes in the poverty level.

The Committee notes that individuals who qualify for Medicaid eligibility under this new optional categorically needy group may not "spend-down" and obtain coverage by incurring large medical expenses. To be covered, an individual or family must meet the State-established income and resource standard without regard to medical expenses. However, the Committee intends that, in States which offer coverage to the "medically needy," elderly and disabled beneficiaries who qualify under the income levels set for the new optional group not be required to "spend down" further to the State's "medically needy" income level. Income would be determined using SSI methodologies.

To qualify for coverage, elderly and disabled individuals would have to meet the resource requirements of the SSI program, with the following exception. If a State offers Medicaid coverage to the "medically needy," it is permitted, at its option, to use the resources standards that it uses for its "medically needy" program instead of the SSI resource standards. This will permit States that wish to reach more low-income elderly and disabled to do so.

Benefits offered to this new optional group of elderly and disabled individuals would have to be the same in amount, duration, and scope as the Medicaid benefits offered by the State to its categorically needy cash assistance recipients, including payment of Medicare premiums and cost-sharing requirements for individuals eligible for both programs. In most States, the basic Medicaid service package includes prescription drugs, nursing home care, eyeglasses, hearing aids, and dentures. These benefits are especially valuable to the low income elderly since they are not covered under the Medicare program.

In addition, individuals covered by this provision will be protected from out-of-pocket physician expenditures if they receive care from physicians who participate in Medicaid. The Committee intends that those covered under this option be treated like other elderly and disabled Medicare beneficiaries and have their physician services under Medicare rendered on an assigned basis. Therefore, if the Medicare physician elects to collect the 20 percent coinsurance on the Medicare claim from the Medicare program, he or she must accept the Medicare payment amount as payment in full and bill the patient for the difference between his or her actual charge and the Medicare allowable charge.

The Committee anticipates that benefits provided to those entitled under this provision will primarily be acute medical care services. The Committee does not view this provision as an expansion of eligibility for long-term care benefits under Medicare. The income eligibility levels under Medicaid for the institutionalized are generally higher than poverty level standard under this provision. Therefore, the Committee does not expect that income stand-

ards for eligibility for nursing home care will be altered by this provision.

The Committee strongly encourages States to expand Medicaid coverage to additional low-income elderly and disabled individuals. The Committee hopes that the provision of Federal Medicaid matching funds for State expenditures on behalf of this new population will be an incentive to the States to cover additional poor elderly and disabled beneficiaries to help assure adequate access to health care services and financial protection against burdensome medical expenses. Under the Committee bill, Federal Medicaid matching funds would be available for expenditures for this new optional group on or after July 1, 1987.

Optional coverage of poor Medicare beneficiaries for Medicare cost-sharing requirements (Sec. 4603)

Under current law, low-income Medicare beneficiaries who are also eligible for Medicare in effect supplement their Medicare benefits with the services offered under Medicaid in their State. These Medicaid benefits generally include prescription drugs, dental care, hearing aids, and nursing home care, plus payment of Medicare's cost-sharing requirements. These include the Part A deductible and coinsurance requirements and the Part B premium, deductible, and coinsurance requirements.

Section 4602 of the Committee bill allows the States to expand eligibility for the elderly and disabled with incomes up to the poverty line for the full range of Medicaid benefits offered by the State to its cash assistance recipients. This section gives the States another, more limited, option. States would be permitted to pay just for the Medicare Part B premium and the other Parts A and B cost-sharing requirements for Medicare beneficiaries whose incomes are below a threshold set by the State, up to the Federal poverty line. States would determine whether they wished to offer this assistance and, if so, where to set the income eligibility standards. However, if a State offered to cover the Medicare cost-sharing expenses of any elderly and disabled, it would have to cover some pregnant women and children in the new optional categorically needy group established by section 4601 of the Committee bill.

Unlike those elderly and disabled covered under section 4602, individuals receiving assistance with Medicare cost-sharing obligations would not be treated as Medicaid beneficiaries for all purposes. However, as in the case of the elderly and disabled covered under section 4602, a State opting to offer this more limited coverage would receive Federal matching payments for its expenditures on behalf of these individuals.

To qualify for assistance under this provision, elderly and disabled Medicare beneficiaries would have to meet the income and resource standards established by the State, using SSI counting methodologies. The Committee bill permits States to set income thresholds at any level up to 100 percent of the Federal poverty line, but the threshold must be the same for both the elderly and disabled, and for individuals and couples. Medicare beneficiaries covered under this provision must also meet SSI resource standards or, at State option, the State's "medically needy" standards. The Committee notes that elderly and disabled individuals are not per-

mitted to qualify for assistance with cost-sharing by "spending down," or incurring large medical expenses.

The elderly and disabled covered under this provision would have to be entitled to Hospital Insurance benefits under Medicare Part A. However, they would not have to be covered under Medicare Part B, the optional Supplementary Medical Insurance program. The Committee bill gives States the option to offer to pay the Part B premiums in such circumstances and enroll this new beneficiary group in Part B.

For elderly and disabled individuals whom the State chose to cover, the Medicaid program would pay for the Part B deductible and the beneficiary's 20 percent coinsurance on Part B services. If the beneficiary uses a physician who takes assignment, Medicaid would pay the physician directly for the 20 percent coinsurance and the patient could not be billed for any amounts above the Medicare reasonable charge. However, if the physician elects not to take assignment, the beneficiary would submit the claim for the 20 percent coinsurance requirement to the State Medicaid program and would be liable for an additional amount charged by the physician. The Committee therefore encourages the States to make available to the elderly and disabled assisted under this provision a list of physicians in their communities who will agree to accept assignment.

The Committee hopes the States will elect to extend full Medicaid benefits to the elderly and disabled, as well as to pregnant women and infants, up to the poverty level. However, the Committee recognizes that the fiscal constraints facing many States may preclude the provision of comprehensive coverage for the low-income elderly and disabled population at this time. The Committee has, therefore, made this more limited Medicare cost-sharing option available to the States. The Committee hopes States with constrained resources will consider pursuing this option as a first step to more comprehensive coverage.

Medicaid eligibility for qualified severely impaired individuals (Sec. 4604)

Under current law, low-income individuals who qualify for Medicaid on the basis of disability must, in most States, meet the disability standards of the Supplemental Security Income (SSI) program. (Some States have opted to impose more restrictive disability criteria than those in SSI. These are commonly referred to as the "209(b) States" in reference to the statutory provision which gives them the option to use their 1972 eligibility standards for the elderly and disabled.) For purposes of SSI, an individual is not considered to be disabled if, after a 9-month trial work period, he or she is able to engage in "substantial gainful activity" (SGA), which the Secretary has defined as average counted earnings of over \$300 per month. Loss of disabled status for SSI purposes means loss of categorical eligibility for Medicaid.

For the disabled with severe impairments, this policy creates an obvious and severe disincentive to work. Almost all of these individuals need medical coverage, but the jobs they are likely to hold tend not to offer employee group insurance coverage and tend not to pay sufficient amounts to allow these individuals to afford indi-

vidual coverage. Such coverage, if available to them at all, is generally very expensive and often does not include coverage adequate to the needs of the disabled. If the disabled refrain from working, they will maintain their SSI and Medicaid benefits. If they begin to work, and engage in "SGA," they may lose their Medicaid benefits even though they still have their impairment. For a medically impaired individual to choose work under these circumstances is obviously irrational.

To address this problem, the Disability Amendments of 1980 (P.L. 96-265) added a new section 1619 to the SSI law. Section 1619(a) provides that an individual who loses eligibility for SSI because he or she has worked and demonstrated the ability to engage in "SGA," but who continues to have a disabling impairment, may become eligible for special SSI benefits until his or her countable income reaches the SSI income disregard "break-even" point (\$756 per month in 1986 in a State with no supplementation). Those who qualify for these special SSI benefits continue to be eligible for Medicaid as long as they need medical assistance to continue working.

Section 1619(b) provides Medicaid coverage for individuals whose earnings exceed the SSI income disregard "breakeven point." This special Medicaid eligibility status applies so long as the individual: (1) continues to be blind or have a disabling impairment; (2) except for earnings, continues to meet all the other requirements for SSI eligibility; (3) would be seriously inhibited from continuing to work by the loss of Medicaid coverage; and (4) has earnings that are not sufficient to provide a reasonable equivalent of the Medicaid and SSI benefits that would have been available if he or she did not work. The Social Security Administration (SSA) has established a "threshold" in each State based on SSI and State supplementary payment levels and the State's average per capita Medicaid expenditures; individuals with gross earnings in excess of this "threshold" no longer meet requirement (4) and therefore lose Medicaid coverage, unless their individual medical expenses exceed the State's average Medicaid expenditures.

According to the Social Security Administration, section 1619 has enabled nearly 9,000 former SSI recipients to retain Medicaid coverage despite returning to work and performing "SGA." Unfortunately, this section expires on June 30, 1987, threatening the ability of these and future disabled individuals to obtain employment or to continue working. In the view of the Committee, extension of this provision is essential to the ability of the disabled to achieve their maximum feasible potential and to be fully contributing members of society.

The Committee bill amends Title XIX of the Social Security Act to establish a new mandatory, categorically needy coverage group: "qualified severely impaired individuals." This group includes any individual under 65 who received either SSI, State supplementation, or special 1619(a) benefits and who: (1) continues to be blind or have a disabling physical or mental impairment; (2) except for earnings, continues to meet all other requirements for SSI eligibility (including having unearned income below the SSI benefit standard); (3) would be seriously inhibited by the lack of Medicaid coverage from continuing to work or from obtaining employment; and (4)

has earnings that are not sufficient to provide a reasonable equivalent of the Medicaid, SSI and Title XX attendant care benefits that would be available if he or she did not work. This mandatory coverage group applies both in States that currently follow the SSI definition of disability and in the "209(b)" States. This provision is effective July 1, 1987, immediately upon the expiration of the current section 1619(b).

The Committee recognizes that, as currently structured, section 1619 is not as effective as it should be in eliminating the work disincentives inherent in the SSI/Medicaid definition of disability. The Committee is aware that the Department has completed a study of the operation of section 1619, including an evaluation of the continued Medicaid coverage provisions; unfortunately, the Department is unwilling to release the results of the study and the Committee does not at this time have the benefit of this analysis. Rather than allow this important provision to expire, however, the Committee has decided to make it a permanent part of Medicaid law in its current form. To the extent that disabled individuals have been reluctant to risk the loss of cash benefits and medical coverage should section 1619 not be renewed, making the Medicaid coverage permanent should, in and of itself, increase the provision's work incentive. However, the Committee does intend to pursue structural reform of this provision, and it urges the Department to release its study so that this work can begin.

Clarification of eligibility of homeless individuals (Sec. 4605)

Under current law, States are prohibited from imposing residency requirements that exclude any otherwise qualified individual who resides in the State. There is no Federal requirement that an individual have a fixed or permanent residence in order to qualify for Medicaid. However, according to the Department of Health and Human Services and the General Accounting Office, some States and localities require applicants for Medicaid and AFDC to supply a fixed address in order to qualify. It appears that these requirements are imposed out of concern by the States that the Federal government will penalize them if they approve fraudulent applications from homeless recipients.

This nation's homeless are, by definition, the poorest of the poor. Whether they are street people, deinstitutionalized chronically mentally ill, newly unemployed, or displaced women and children, the homeless have serious health and mental health problems which are aggravated by poor clothing, constant exposure to the elements, poor nutrition, and overcrowding in shelters. These individuals do not have the income or resources to pay for needed medical care, and Medicaid is the logical source of coverage for them. Of course, only those homeless who meet Medicaid's categorical requirements (aged, blind, disabled, or member of a family with dependent children) as well as income and resource standards may qualify. However, many do meet these tests.

In the view of the Committee, there is no justification whatsoever for denying Medicaid coverage to an otherwise qualified homeless person simply because of that individual's lack of a fixed or permanent address. It unfairly penalizes the homeless and those hospitals and physicians who are willing to provide needed medical

care to them despite their inability to pay. It may also result in the denial of medical treatment to the homeless, among whom the incidence of tuberculosis is high, creating an avoidable threat to public health.

The Committee bill therefore clarifies that States or localities are prohibited from imposing any residence requirement which excludes from Medicaid any otherwise qualified individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address. The Committee intends that the otherwise qualified homeless be able to establish residency through the use of a mailing address at a shelter or similar facility, or by affidavit, or through any other means consistent with the circumstances under which the homeless live.

Treatment of income and resources required to be paid under spousal or child support orders (Sec. 4606)

The Medicaid statute provides that, in determining eligibility, States take into account only such income and resources as are "available" to the applicant or recipient, in accordance with standards prescribed by the Secretary. It has come to the Committee's attention that HCFA is attempting to prohibit some States from treating the income used to pay spousal and child support payments as unavailable to aged, blind, and disabled Medicaid beneficiaries when determining their income. For example, HCFA has recently disapproved a California State Plan amendment that permits an income disregard of spousal and child support made under court or by agreement with a district attorney on the grounds that income actually received is "available," even if it must later be used to make support payments.

The Committee finds HCFA's position untenable. The Committee fails to understand how income which must, by law, be used for the support of someone other than the Medicaid beneficiary can be "available" to him or her. The very purpose of a requirement at section 1902(a)(17)(B) of the Act that States take into account only such income and resources as are available is to prevent them from including in income the actual amounts that an applicant or beneficiary is legally compelled to use for someone else's support.

Consider the case of a low-income elderly couple where the pension and Social Security income is all in the husband's name. If the husband requires nursing home placement and is otherwise qualified for Medicaid, under current law all of the husband's income (except a \$25 monthly personal needs allowance) would be applied to his nursing home bill, with the Medicaid program paying the difference between the husband's contribution and the facility's reimbursement rate. This obviously leaves the wife in an untenable financial position, since she is then without income from either her husband's pension or Social Security benefits. In a number of States, community spouses have had no choice but to go to court and sue their institutionalized spouses for support in an effort to avoid pauperization and having to go on welfare. Under HCFA's interpretation, the amount which the institutionalized spouse is required to pay under these support orders is still considered "available" to him, so that it can be used to pay the nursing home bill, even though he may face civil contempt proceedings or other judi-

cial sanctions for failure to make payment to his spouse. In effect, HCFA believes that Congress intends for the support payment to be applied to the nursing home bill rather than to the maintenance of the community spouse, as the court ordered. HCFA is wrong.

Title XIX forbids HCFA—or the States—from requiring beneficiaries to make the Hobson's choice of either using all of their income to meet their own needs as a condition of Medicaid eligibility, or meeting their court-ordered support obligations and doing without medically necessary care. It is the Committee's understanding that the Social Security Administration's Program Operations Manual System (POMS) recognizes that income which must be used to make family support payments pursuant to court order or pursuant to an agreement with a District Attorney is not available for "deeming" to an SSI recipient (POMS section 00850.140). This same principle applies to Medicaid under section 1902(a)(17)(B) of the Act: income which must be used to make child or spousal support payments is not available to meet the beneficiary's own needs.

To clarify this situation, the Committee bill makes explicit that, in determining the income and resources of an individual who is in an institution, the individual shall not be considered to have available to him or her income or resources which are required to be paid under court order for the support of the individual's spouse or child, up to the amount required by the court order. The Committee recognizes that Congress in 1984 required States to establish expedited processes for establishing and enforcing child support obligations. Under such processes, support orders generally will be awarded administratively rather than by court order. The Committee therefore intends that the term "under court order" as used in this amendment apply not only to court ordered support, but also to any other directive with the force of law, including an administrative order and an agreement with the district attorney.

The Committee amendment applies to States which had the policy or practice of disregarding such support payments in such circumstances as of July 22, 1986, without regard to whether or not the policy or practice, reflected in a State plan amendment or not, was approved by HCFA. Because the issue of support-obligated income has arisen in the context of HCFA disapprovals of State proposals to disregard support obligations of SSI-related applicants and recipients, the Committee has limited the scope of this amendment to the support obligations of institutionalized individuals in States that have already attempted to effect this policy or practice. Thus, in addition to the States that are actually implementing such a policy, this provision also applies to those States that are under court order to disregard amounts allocated for support, and those that, as of July 22, 1986, have attempted to implement a disregard for support-obligated funds on behalf of institutionalized individuals but have been informed by HCFA, in writing or verbally, that they cannot institute such a policy or practice.

Payment for aliens under Medicaid (Sec. 4607)

The Medicaid statute does not explicitly identify whether otherwise qualified aliens are entitled to benefits. By regulation, the Secretary has limited Medicaid eligibility to otherwise eligible aliens

who are lawfully admitted for permanent residence or permanently residing in the U.S. under color of law, including any alien who is lawfully present under sec. 203(a)(7) or sec. 212(d)(5) of the Immigration and Nationality Act. The Aid to Families with Dependent Children (AFDC) statute, section 402(a)(33) of the Social Security Act, and the Supplemental Security Income (SSI) statute, section 1614(a)(1)(B) of the Act, both limit eligibility for cash assistance benefits to otherwise qualified aliens who are lawfully admitted for permanent residence or otherwise permanently residing in the U.S. under color of law.

On July 14, 1986, a U.S. District Court struck down this regulation as outside the scope of the authority delegated under the Medicaid statute. *Lewis v. Gross*, No. CV-79-1740 (E.D.N.Y., July 14, 1986). The Court reasoned that Congress "knew how to impose alienage requirements on social welfare programs when it intended, and its refusal to impose such a requirement on Medicaid should be respected." Because the AFDC and SSI statutes do include explicit exclusions of certain classes of aliens, the result of this decision is that otherwise qualified aliens who are eligible for Medicaid as non-cash beneficiaries—i.e., medically needy or optional categorically needy individuals—are entitled to Medicaid coverage.

In response to the Court's invitation to clarify Congressional intent, the Committee bill amends the Medicaid statute to make it explicit that Federal financial participation is not available for State expenditures for aliens who are not lawfully admitted for permanent residence or permanently residing in the U.S. under color of law. The bill also provides that nothing in the Medicaid title should be construed to require a State plan to offer coverage to aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the U.S. under color of law. The Committee intends that the Secretary and the States broadly interpret the phrase "under color of law" to include all of the categories recognized by immigration law, policy, and practice in effect at the time, including Cuban-Haitian entrants (as defined in paragraph (1) or 2(A) of section 501(e) of Public Law 96-422, as in effect on April 1, 1983).

Permitting States to offer home and community-based services to low income individuals with Acquired Immune Deficiency Syndrome (AIDS) or with AIDS-related conditions (Sec. 4611)

Under current law, the Secretary is authorized, upon application by a State, to grant a "2176" waiver allowing Federal Medicaid matching funds to be used to purchase home or community-based services to Medicaid eligible individuals who are determined to require the level of care provided in a skilled nursing facility (SNF) or an intermediate care facility (ICF), including an intermediate care facility for the mentally retarded (ICF/MR). (Section 2176 of the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, created section 1915(c) of the Social Security Act, the source of the Secretary's 2176 waiver authority). With respect to low-income individuals who are at risk solely of inpatient hospital care, however, only ventilator-dependent individuals who, but for waived services,

would continue to receive inpatient hospital care, may be covered under a waiver.

Home and community-based services that may be provided with Federal matching payments under the waivers include case management, homemaker/home health aid, personal care, adult day health, habilitation, respite care, and such other services as the Secretary may approve, other than room and board. In order to receive a waiver, States must satisfy the Secretary that, among other things, the waiver will be budget-neutral. That is, the average annual per capita Medicaid expenditure estimated by the State for individuals receiving home- and community-based services under a waiver must not exceed the average per capita Medicaid expenditure the State reasonably estimates would have been made in the fiscal year for these individuals if the waiver had not been granted.

As of mid-July of 1986, the Centers for Disease Control (CDC) reported over 22,000 confirmed cases of Acquired Immune Deficiency Syndrome (AIDS). AIDS is a disease characterized by a collapse of the immune function and by resultant opportunistic infections and conditions, most commonly pneumocystis pneumonia and Kaposi's sarcoma. The disease was first identified in 1981 and is thought to be caused by the virus known as HTLV-III/LAV, or Human Immunodeficiency Virus (HIV). AIDS is the most severe form of HIV infection, although a number of other AIDS-related conditions, ranging from asymptomatic HIV infection and lymphadenopathy to AIDS-Related Complex (ARC) and neurological impairments, have been identified. At this time, there is no known cure for AIDS, and the disease is thought to be terminal in all cases. On average, the time between diagnosis and death is less than 2 years.

In a June, 1986, report, the Public Health Service (PHS) estimated that by the end of 1991, more than 270,000 Americans will have been diagnosed with this disease and that 179,000 Americans will have died of it. The PHS also estimated that in that year alone, more than 145,000 cases of AIDS will require medical care. The PHS makes special note that, because of under-reporting of cases, these estimates may be as much as 20 percent below actual experience. None of these estimates include persons with AIDS-related conditions but without the fully-developed AIDS disease.

The costs of caring for AIDS patients are substantial. In an initial study, the CDC has estimated that the average number of hospital days for AIDS patients exceeds 150 days, and the average cost per patient is in excess of \$140,000, exclusive of outpatient support services, tests, medications, home care, or counseling. Using this figure, the total public and private cost of health care for persons with AIDS in 1991 can be calculated to be \$24 billion, or approximately 3.6 percent of the total estimated U.S. personal health care expenditures for that year.

However, in testimony presented to the Subcommittee at hearings in July and November of 1985 and in March of 1986, it has been demonstrated that it is possible to reduce substantially the total medical costs of caring for AIDS patients adequately and appropriately. In San Francisco, for example, where a range of community care is available, hospital costs have been held, on average, to \$29,000 per AIDS case. Such reduced costs have been achieved

through a model community-based service system that seeks to avoid costly hospital care whenever possible.

In its June, 1986 report, the PHS recommended that such model services be made more widely available. If a continuum of hospital, home-health, hospice, and personal care were available by 1991, the PHS estimated that the average cost per patient could be reduced to \$46,000 per case from its estimate of \$140,000 per case. Even with such services—and their resulting savings—assumed to be in place within five years, the PHS estimated that the total public and private costs of providing health care for persons with AIDS in 1991 would be between \$8 billion and \$16 billion.

AIDS and its related conditions are without known therapies. Individuals with a diagnosis of AIDS are considered presumptively disabled for purposes of Supplemental Security Income (SSI). Most victims of this debilitating disease eventually lose their jobs and their employment-related health insurance. Those who impoverish themselves due to high medical expenses and loss of income can be expected to become eligible for SSI and/or Medicaid. The Committee anticipates that the Medicaid program will be responsible for paying for a significant share of the growing costs of AIDS care.

The Committee observes that Medicaid coverage is important not only for the AIDS patient, but also for providers of care. Uninsured AIDS patients pose a serious financial burden for those public and private hospitals that treat them. In the November and March hearings before the Subcommittee, testimony was received regarding the fiscal difficulties the AIDS epidemic presents for those hospitals that already serve large numbers of Medicaid and non-paying patients.

It is the Committee's intention to assure that the Medicaid funds for AIDS care are spent in as cost-effective and appropriate a manner as possible. It is clear to the Committee that the substitution of community-based care for hospital care, where medically and socially appropriate, is essential. Witnesses before the Subcommittee stressed the need for Medicaid to finance alternatives to hospital care for AIDS patients and documented the potential savings from community services as an alternative to hospital care. Similarly, in its June, 1986 report, the PHS recommended that consortia of service delivery systems (including hospital, mental health, home health and hospice care) be developed to meet the growing needs of persons with AIDS and further recommended that model waiver programs be initiated.

The Committee bill therefore amends the current Medicaid "2176" waiver authority to permit States to offer home- and community-based services to Medicaid-eligible individuals with AIDS or with AIDS-related conditions who, but for the provision of home- and community-based services, would continue to receive inpatient hospital or nursing home care. The Committee intends that the term "AIDS-related conditions include opportunistic infections, neurological complications, and the AIDS-Related Complex (ARC), and comprise a cluster of AIDS-related conditions recognized by the PHS as a clinical manifestations of an infection by the same virus that causes AIDS. It is the Committee's expectation that the implementation of this waiver authority will encourage other jurisdic-

tions to develop community-based services comparable to those in San Francisco.

The provision makes no other changes with regard to the 2176 waiver authority. As under current law with respect to other waiver populations, States would retain the option as to whether to request the waiver, which populations and areas of the State to target, and what non-institutional services to offer to the target population. States would also have to satisfy the Secretary that the estimated expenditures for the target population under the waiver would not exceed the estimated expenditures for the target population in the absence of the waiver. The Committee wishes to emphasize that, as with respect to other "2176" waivers, States need not demonstrate cost savings; they need only demonstrate budget neutrality. In making estimates for complying with the budget-neutrality test, States may use average per capita hospital costs for hospitalized AIDS patients in the target area, and are not required to use the per capita expenditures for all Medicaid-eligible hospital patients in that area or throughout the State.

The Committee provision also clarifies that States are permitted to target the existing optional "case management" benefit to eligible individuals with AIDS and AIDS-related conditions in certain areas within the State. The purpose of these services is to increase beneficiary access to needed medical, social, educational, and other services. The Committee bill makes clear that this optional benefit, which can be limited to certain regions of a State or to certain covered groups, may also be targeted specifically on individuals with AIDS or AIDS-related conditions.

The Committee notes that this amendment does not expand Medicaid eligibility to new beneficiaries. It merely permits States, under conditions of budget-neutrality, to offer home and community-based care as an alternative to more costly hospital care for Medicaid-eligible patients with AIDS and AIDS-related conditions.

The Committee believes that home and community-based waivers for AIDS patients will result in substantial savings to the Medicaid program and the Federal government. The San Francisco experience shows that new services in the community reduce rather than expand the cost per case for AIDS patients. Although the Congressional Budget Office has estimated that this provision will not increase Federal outlays, the Committee expects its implementation to save Federal and State Medicaid dollars.

Permitting States to offer home- and community-based services to low-income individuals with chronic mental illness (Sec. 4612)

Under current law, the Secretary is authorized to waive certain Medicaid requirements in order to enable the States to make home- and community-based services available to Medicaid-eligible individuals who are at risk of skilled nursing facility or intermediate care facility services. This authority, often referred to as the "2176 waiver," can be exercised only where the Secretary determines that the average per capita Medicaid cost of providing waived services to the target population would not exceed the average per capita Medicaid cost in the absence of the waiver.

In 1985, the Secretary reported to the Congress that, as of December 31, 1984, a total of 86 waivers had been approved under

this authority; however, less than 5 covered the chronically mentally ill who are eligible for Medicaid. This, in the view of the Committee, is unfortunate. A number of well-designed studies have shown that model community-based programs for the chronically mentally ill are feasible to implement, preferred by patients, lead to improved patient functioning, and are affordable. Yet the incentives in current Medicaid reimbursement policies are to use expensive general hospital psychiatric services rather than alternative care settings. There is reason to believe that, by using Medicaid funds to purchase out-of-hospital services for the chronically mentally ill, States could substantially reduce acute hospital costs for this population by reducing lengths of stay and readmissions.

To facilitate State efforts in this regard, the Committee bill expands the scope of the "2176" waiver authority to include those individuals who, but for the provision of home- and community-based services, would continue to receive inpatient hospital (or nursing home) services because they have chronic mental illness, the treatment of which is covered under the State's Medicaid plan. The hospital services referred to include both mental health services provided by general hospitals and those provided by psychiatric hospitals. In making estimates for determining whether a waiver proposal will meet the budget neutrality test in section 1915(c)(2)(D) of the Act, States may use the average per capita hospital care expenditures for chronically mentally ill individuals, and are not required to use the per capita expenditures for all Medicaid-eligible hospital patients.

The Committee bill specifically provides that a State would be able to offer under such a waiver services appropriate to the chronically mentally ill, such as day treatment and other partial hospitalization services, psychosocial rehabilitation services, and clinic services. The Committee wishes to emphasize that the waived clinic services need not be provided in the facility itself; they may be provided by the clinic staff at another site, such as a shelter for the homeless.

As an alternative to, or in conjunction with, a "2176" waiver, some States may prefer simply to target case management services on the Medicaid-eligible chronically mentally ill. The purpose of these services is to increase beneficiary access to needed medical, social, educational, and other services. The Committee bill makes clear that this optional benefit, which can be limited to certain regions of a State or to certain covered groups, may also be targeted specifically on individuals with chronic mental illness.

Waiver authority for the chronically mentally ill demonstration program (Sec. 4613)

Under current law, States cannot enter into any contracts with providers to deliver services to Medicaid beneficiaries on a prepayment or other risk basis unless the requirements of section 1903(m) of the Act are met. These requirements, which are intended to protect the patients from underservicing and poor quality care and the program from financial abuse, include a provision limiting the number of enrolled Medicaid (or Medicare) beneficiaries to 75 percent of a contractor's total prepaid enrollment. This prevents

States from entering into capitation arrangements with all-medic-aid prepaid plans.

Early this year, the Robert Wood Johnson Foundation and the Department of Housing and Urban Development initiated a Program for the Chronically Mentally Ill under which the Foundation will provide \$28 million in grants and low interest loans, and the Department will provide rent subsidies, to develop community-wide systems of care and rehabilitation and to expand housing options for the chronically mentally ill over a 5-year period. Eight of the nation's 60 largest urban centers will be selected to participate on a competitive basis. Grants of up to \$2.5 million each, and low-interest loans of up to \$1 million each, will be made to support the development of community-wide mental health authorities that offer a range of services. The Social Security Administration will work with grantees to improve the disability determination process.

Among the applications for this Program are proposals to enroll, on a risk basis, those chronically mentally ill who are eligible for Medicaid into the delivery systems organized by the grantee mental health authorities. For example, the Philadelphia county mental health authority proposes to contract with the State on a prospective per capita basis for all Medicaid mental health services in that city. Social workers and nurses working in 60 teams, each with a psychiatrist paid on a per capita basis, will provide 24-hour-per-day continuing care for the most seriously impaired mentally ill, most of whom are high users of general hospital care for acute psychiatric crisis. The current Medicaid requirements relating to prepayment arrangements may create a barrier to the implementation of such a proposal, should the Foundation and HUD find it otherwise qualified to fund.

While the Committee is extremely reluctant to alter the current Medicaid prepayment protections, it recognizes that this public-private initiative has the potential to improve both the quality and cost-effectiveness of the care available to the chronically mentally ill who are eligible for Medicaid. The Committee bill therefore creates a special waiver authority to enable the States, at their option, to enroll the Medicaid-eligible chronically mentally ill residing in one of the grantee areas in the participating mental health authority on a capitation basis. In order to grant such a waiver, the Secretary must determine (1) that the program is receiving funding under the Robert Wood Johnson Foundation/HUD Program for the Chronically Mentally Ill, (2) that the State has provided satisfactory assurances that, with respect to Medicaid-funded mental health services, the demonstration will be budget neutral, and (3) that Medicaid-eligible chronically mentally ill individuals will not experience any reduction or limitation in the amount, duration, or scope of services to which they are entitled under the State's Medicaid plan. The Committee wishes to stress that, if a grantee is defunded by the Program for the Chronically Mentally Ill, the Secretary is to terminate any waivers granted under this authority.

The Secretary is authorized to waive the requirements of state-wideness, comparability, and freedom of choice of provider as needed to implement this demonstration, but only with respect to the provision of mental health services. With respect to medical

services covered under the State plan, current Medicaid protections would apply to the eligible individuals affected; thus, they could continue to receive their regular medical care from the providers of their choice. The Committee bill also authorizes the Secretary to waive two of the current prepayment rules at section 1903(m): the requirement that the mental health authority be an HMO for Medical purposes, and the 75 percent ceiling on Medicaid/Medicare enrollment. All other current provisions, such as the requirement that capitation rates be actuarially sound and the enrollees be able to disenroll upon one month's notice without cause, would be applicable.

Among the services that grantees could offer under this waiver authority are case management for the chronically mentally ill, habilitation services, day treatment or other partial hospitalization services, residential services (other than room and board), psychosocial rehabilitation services, clinic services (whether or not furnished in a facility), and such other services as the Secretary may approve. Waivers would be granted for an initial term of 3 years, and could be renewed for an additional 2 years. A report on the cost, accessibility, utilization, and quality of services provided under these waivers is due to the Congress on January 1, 1993. The Committee views this demonstration as an excellent opportunity to learn how to improve the design of the Medicaid program with respect to the chronically mentally ill and looks forward to receiving the Secretary's evaluation.

The Committee wishes to emphasize that the Secretary may not require that waivers under this section actually save money. It is sufficient if the average per capita Medicaid expenditure estimated by the State for mental health services to the waiver population does not exceed 100 percent of the average per capita expenditure that would have been made for mental health services, including inpatient care provided in a general or psychiatric hospital, in the absence of the waiver. As with the existing "2176" waivers, the Secretary may not require that the actual total expenditures for such a waiver cannot exceed the approved estimates for such services.

Continuation of "Case-Managed Medical Care for Nursing Home Patients" Demonstration Project (Sec. 4614)

The Massachusetts Department of Public Welfare is currently operating a Medicaid/Medicare demonstration project designed to reduce inappropriate and costly hospitalizations and to improve the quality of primary care provided to nursing home patients. Under the "Case-Managed Medical Care for Nursing Home Patients" demonstration, the State reimburses primary care visits to Medicaid-eligible nursing home patients by nurse practitioners and physician assistants, diverting these patients from unnecessary hospitalizations and visits to hospital outpatient clinics and emergency rooms. The demonstration's HCFA-approved budget for this year projects Federal savings of \$2.3 million.

To enable the State to implement this demonstration, the Secretary has waived certain Medicaid (and Medicare) requirements from July 1, 1983, through June 30, 1987. An evaluation of the project, conducted jointly by HCFA and the RAND Corporation, is

now underway. The Committee bill requires the Secretary, upon application by the State, to extend the demonstration through June 30, 1989, to allow time for completion of the evaluation.

Holding States harmless in fiscal year 1987 against a decrease in the Federal medical assistance percentage (Sec. 4621)

The Federal Medicaid matching rate to any given State is based on the average per capita income of the State and the U.S. for the three most recent calendar years for which satisfactory data are available. Prior to the enactment of the Consolidated Omnibus Budget Reconciliation Act, P.L. 99-272, this matching rate was updated every two years. Section 9528 of COBRA requires an annual, rather than biennial, updating of the rate, effective beginning in FY 1987. The COBRA conferees expressed their intention that "the committees of jurisdiction will explore ways to relieve the hardship that may be suffered by the States that will receive substantially less in matching payments as a result of this provision."

The annual update mandated by COBRA decreases the Federal Medicaid matching rate in 13 States, resulting in a loss of Federal Medicaid funds vis-a-vis what they would have received under the rate applicable under previous law. These States are: Arizona, Florida, Georgia, Maine, Minnesota, Missouri, New Hampshire, North Carolina, Ohio, Rhode Island, South Carolina, South Dakota, and Virginia. In the view of the Committee, it would be inequitable to impose financial hardship on these States and their Medicaid beneficiaries. The Committee bill therefore provides that section 9528 of COBRA shall not apply to these adversely impacted States during FY 1987; their Federal matching rates will therefore remain unchanged from those applicable in FY 1986.

Independent quality review of HMO services (Sec. 4631)

Current HCFA regulations require entities which serve Medicaid beneficiaries on a prepayment or other basis must have internal quality assurance systems meeting certain specifications. There is no regulatory or statutory requirement that an external organization, independent of both the prepaid plan and the State Medicaid agency, monitor the quality of services rendered to Medicaid patients. The Medicare statute, in contrast, requires that, effective January 1, 1987, the quality of services delivered on a risk basis by Health Maintenance Organizations (HMO's) and Competitive Medical Plans are subject to review by Professional Review Organizations (PRO's).

In the view of the Committee, the need for independent, external monitoring of the quality of services provided by HMO's, Health Insuring Organizations (HIO's), and other prepaid plans is as compelling in the Medicaid programs as it is in the Medicare program. The Committee notes that the Arizona Health Care Cost Containment System (AHCCCS) demonstration project, under which all care to Medicaid beneficiaries is delivered on a prepayment basis, decided to contract with a private accreditation organization to undertake annual medical audits of all the participating prepaid plans after serious concerns have been raised regarding the quality of care being delivered.

The Committee bill requires that States provide for an independent, external review of the quality of services provided or arranged by each HMO, HIO, or other prepaid plan with which the State has entered into a risk-based contract. The review must be conducted on an annual basis, and it must be specific to the quality of services provided to Medicaid enrollees. A State may select either a PRO or a private accreditation organization for this purpose; it may not, however, use any of its own agencies to fulfill this requirement. Federal matching payments would of course be available for State expenditures for this purpose. The results of these reviews must be made available, on request, to the Secretary, the Inspector General, and the Comptroller General. The requirement is effective July 1, 1987.

Clarification of flexibility of State utilization review systems (Sec. 4632)

Under current law, States may, at their option, implement second surgical opinion programs or inpatient hospital preadmission review programs. According to HCFA, 42 State programs currently have some type of second surgical opinion program, most of which are voluntary. Mandatory programs, under which Medicaid does not reimburse a physician for performing a covered surgical procedure without a second opinion, have been adopted in 10 States (Massachusetts, Michigan, Minnesota, Missouri, New Jersey, Oregon, Tennessee, Virginia, Wisconsin, and Washington), and other (New York) are in the process of establishing them.

Recently, HCFA published a proposed rule that would require every State to have in place, by January 1, 1987, a mandatory second surgical opinion program conforming to HCFA specifications or, in the alternative, an existing utilization review plan that prevents unnecessary surgery, is cost-effective, and meets HCFA's approval. 51 Fed. Reg. 21933 (June 17, 1986). Citing a 10-year-old report by this Committee's Subcommittee on Oversight and Investigations that in turn relied on 1974 national data, HCFA simply assumes that, in 1986, the amount of unnecessary surgery in the Medicaid programs in those States that do not already have mandatory second surgical opinion program is so high as to justify the imposition of a national mandate.

There are only two problems with this proposed rule: the basic policy premise is unsupported by current evidence, and HCFA does not have the statutory authority to impose such a requirement. The Committee urges the Secretary to withdraw this ill-advised and unauthorized proposal.

In the view of the Committee, HCFA has not documented the extent of unnecessary surgery in those 8 States that do not have either a voluntary or mandatory second surgical opinion program. Nor has HCFA explained why it would be cost-effective for States that now have voluntary programs to institute mandatory programs instead. Under current law, every State has for years had the option to institute a mandatory second surgical opinion program, yet only 10 States have done so, while most of the others, according to HCFA's own data, have opted for voluntary programs. It seems to the Committee ironic that HCFA, which so often stresses the need for flexibility in Federal standards to enable the

States to address their own unique circumstances, now seeks to impose on the states a mandatory review program using national standards—all in the absence of any data on the extent of unnecessary surgery in the States without mandatory programs.

The Committee bill makes clear the Secretary does not have, and never had, the authority to require that States operate second surgical opinion programs, whether voluntary or mandatory, or that States operate inpatient hospital preadmission review programs. Those States that are currently operating mandatory or voluntary second surgical opinion programs could continue to do so. Similarly, States that do not now have such programs will continue to be free to implement them, at their option. Finally, those States that do not want to implement such programs, whether they feel it is not cost-effective or because they prefer other utilization control measures, will remain free not to so.

The Committee is unwilling to allow HCFA to impose this regulatory burden on the States, participating physicians, and beneficiaries in the absence of methodologically sound, up-to-date, information as to the extent of unnecessary surgery in the Medicaid program. The Committee bill therefore requires that the Secretary report to the Congress, by January 1992, on the extent of unnecessary surgery and the identity of those procedures that should be targeted for review. The Committee is also concerned that, in some States or for some procedures, the problem is not so much overutilization of surgery as underutilization, due to the low level of physician participation in the program. The Committee bill requires that the Secretary's report speak to this issue as well.

More specifically, the Secretary is required, for each State in a representative sample of States, to describe (1) the high-volume or high-cost procedures used by Medicaid patients; (2) payment rates and aggregate spending for those procedures; (3) the extent of geographic variation in the rate of performance of such procedures; (4) the rate at which the procedure is performed on Medicaid patients compared to private patients; and (5) the number of physicians willing and qualified to perform second opinions. It is the Committee's intent that in determining high cost procedures, the Secretary look at those procedures that are high cost on a per unit basis as well as a procedure that, while not costly on an individual basis, result in a high level of Medicaid expenditures because of the frequency with which they are performed.

In conducting this study, the Secretary is to select a representative sample of States for data collection and analysis. At least 6 States, none of which operate mandatory second surgical opinion programs, should be included in the analysis. The States selected should be geographically representative and permit analysis of variations between urban and rural areas. For comparative purposes, and with appropriate controls, the utilization experience in those States that do operate mandatory programs should be compared to that of the study States to assess the impact of second surgical opinion programs on use of high volume or high cost procedures.

The Committee is concerned that the implementation of mandatory second opinion surgical programs may in some States have the effect of reducing access to needed care for Medicaid beneficiaries

by discouraging physicians from participating in the program because of additional paperwork and low payment rates. The Committee is also concerned that if second opinion programs are mandatory for some surgical procedures, beneficiaries may be denied treatment because physicians qualified and willing to render the second opinions are unavailable. The Committee bill therefore requires the Secretary to determine the number of qualified physicians who perform the procedures identified and who would be willing to render a second opinion at the Medicaid payment rate. The Committee recognized that this provision may require the Secretary to survey the physicians in the sample States, but this information seems to the Committee essential if an informed policy judgment on mandating second opinion programs is to be made.

The Committee is concerned not only about overuse of services by Medicaid beneficiaries, but also by underuse. The Secretary's report is therefore to identify those procedures and services which appear to be underused by the Medicaid population. Specifically, Medicaid utilization rates are to be compared to the utilization rates of privately-insured patients of comparable age and sex. The report should also compare utilization rates for procedures between the States in the study to identify procedures that are high volume in one State and low volume in another. This information can be unduly restricting access to care for some Medicaid beneficiaries.

Clarification of flexibility for State Medicaid payment systems for inpatient services (Sec. 4633)

Under current law, States must find, and give the Secretary adequate assurances that, the rates of payment for covered inpatient hospital services are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." This standard, enacted in section 2173 of the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, replaced the previous requirement that States use the Medicare "reasonable cost" payment methodology unless they obtained approval from the Secretary to use an alternate reimbursement method. The purpose of this statutory change was to give the States greater flexibility, within the contours of the Medicaid statute, in establishing payment rates and methodologies.

Recently, HCFA published a proposed rule which would limit payments for inpatient hospital services or long-term care facility services to hospitals, SNF's, ICF's, and ICF's/MR to the amount that can reasonably be estimated would have been paid for the services under Medicare reimbursement principles in effect at the time the services were furnished. 51 Fed. Reg. 5728 (Feb. 18, 1986). HCFA contends that this proposal is consistent with the intent of sections 1902(a)(13)(A) and 1902(a)(30) of the Act. HCFA is incorrect.

There is no reference to Medicare reimbursement principles in the Medicaid statute with respect to payment for inpatient services for hospitals, SNF's, ICF's, or ICF's/MR, and there has not been any such reference since the enactment of OBRA. The reason for this is quite simple. The Committee has intended, and does intend, that Medicare principles of reimbursement or payment levels not be applied as a limit on Medicaid payments for inpatient services. The Medicaid statute contains a separate set of reimbursement

principles designed to accommodate the needs of both the States and the Federal government in administering the Medicaid program. Medicare payment requirements have neither relevance nor applicability to the Medicaid program. Of course, States have the option to use Medicare payment methodologies and rates if they so choose; however, the Secretary has no authority whatsoever to require them to do so, or to impose Medicare-related limits of any kind on their payment rates.

It has come to the Committee's attention that HCFA has recently attempted to disallow a new Medicaid prospective payment plan for inpatient hospital services adopted by the State of Georgia. HCFA is apparently maintaining that the State's slightly higher payment limits for certain hospitals serving a significantly disproportionate number of low-income patients would cause the State's Medicaid payments to exceed the level of expenditures if payments were calculated under the increase that would have been permitted if Federal Medicare principles of reimbursement were applied. This HCFA position is particularly disturbing to the Committee, not merely because it has no basis in statute, but because the Medicaid statute explicitly requires that, in setting payment rates for inpatient hospital services, States must take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs. Not surprisingly, the State of Georgia is appealing HCFA's disapproval.

It is evident to the Committee that, if this proposed rule is implemented, there will be a great deal of senseless, costly litigation involving Georgia and, eventually, other States, which the Department must inevitably lose, since it has no statutory authority for the imposition of such limits. The Committee therefore urges the Secretary to withdraw the proposed rule. To further clarify Congressional intent on this matter, the Committee bill makes explicit that nothing in the Medicaid statute shall be construed as authorizing the Secretary to limit the amount of payment that may be made with respect to inpatient hospital, SNF, ICF, or ICF/MR services. This includes any limitation, including that in the February 18 proposed rule, relating to the amount that can reasonably be estimated would have been paid for the services under Medicare reimbursement principles.

Financial disclosure requirements for HMO's (Sec. 4634)

Current law requires participating providers to disclose information concerning ownership and control and related party transactions. More particularly, all entities furnishing services under Medicaid must disclose to the State the identity of each person with a control interest or with an ownership interest of 5 percent or more. In addition, participating entities must disclose, upon request by the State or the Secretary, full and complete information as to the ownership of a subcontractor with whom the entity has had business transactions in excess of \$25,000 per year, and as to any significant business transactions with such subcontractor.

The purpose of these disclosure requirements is to protect the financial integrity of the program, and to assure that Federal health care dollars are not diverted to uses other than the delivery of services. This has special applicability with regard to HMO's,

Health Insuring Organizations (HIO's), and other prepaid health plans participating in Medicaid. As the GAO noted in a recent report to the Subcommittee, "Related-party transactions within these corporate structures can enable health plans to divert capitation funds from their intended purpose—the provision of health care. They can lead to unnecessary administrative costs and excessive profits. Underservicing of the Medicaid population may occur if capitation payments are used to pay unnecessary administrative costs or excessive profits to related parties rather than to provide medical care services." *Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans*, GAO/HRD-86-10 (November, 1985) at page 10.

During the course of its review of the Arizona Health Care Cost Containment System (AHCCCS), the GAO found widespread non-compliance with the disclosure requirements. One of the participating prepaid plans that did not disclose, Health Care Providers of Arizona, Inc., was found to be tied to 10 other firms in which its owners had a controlling interest. Two physicians with a combined interest of two-thirds ownership in the plan wholly owned 9 of these firms, 7 of which received payments for the plan for various medical services. In April, 1985, after 30 months in AHCCCS, the State terminated its contract with Health Care Providers for failing to meet outstanding liabilities. At that time, it was the third largest plan in the AHCCCS program with about 4,000 Federally-funded Medicaid enrollees. GAO estimates that the plan received roughly \$4 million in Federal Medicaid funds before its financial collapse. The GAO concluded that, due to noncompliance with disclosure requirements, "HCFA and the State do not know whether capitation funds are being appropriately used to provide health care services for Arizona's Medicaid population."

It is the firm intent of the Committee to avoid the recurrence of such a debacle. The GAO has made a number of suggestions for tightening the current statutory disclosure requirements in which the Committee finds great merit. Accordingly, the Committee bill requires that HCFA give prior approval to all contracts (or renewals) with HMO's, HIO's, or prepaid plans under which total Federal and State expenditures will exceed \$100,000. This requirement had, prior to 1983, been included in HCFA regulations, but was deleted as part of the Office of Management and Budget's "regulatory reforms." The GAO believes that restoration of this prior approval requirement might avert nondisclosure problems like those that occurred in Arizona.

The Committee bill further requires that each HMO, HIO, or prepaid plan entering into a risk-based contract with Medicaid must disclose to the State a description of all transactions (other than the payment of salaries to employees) between the plan and any party in interest. (This does not apply to Federally-qualified HMO's participating in Medicaid, as these organizations are already required to make such disclosure under the Public Health Service Act). The requirement extends to transactions that occur before as well as after the contract is entered into. The disclosure must occur prior to the initial approval of a contract, and periodically thereafter, as specified by the Secretary in regulations, including prior to any renewal or extension of the contract. The pur-

pose of this requirement is to assure that the State (and, upon request, the Secretary, the Inspector General, and the GAO), is aware of all the parties in interest and the nature of the transactions between the contracting plan and the related parties. This information will assist the State, and the Secretary, in determining whether to approve or renew a risk-based contract. The Committee expects that the Secretary will withhold approval of a contract in any case where the ownership and control arrangements, and the nature and scope of the related party transactions, suggest that Federal Medicaid funds are likely to be diverted or otherwise imprudently spent.

Delegation to Inspector General of authority over State Medicaid fraud control units (Sec. 4635)

Currently, Federal administrative responsibility, including grants management, for the State Medicaid Fraud Control Units rests with the Office of the Inspector General (OIG) in the Department of Health and Human Services. This responsibility was originally placed in the Health Care Financing Administration (HCFA), but on April 15, 1979, was transferred to the OIG.

In the view of the Committee, the appropriate locus of oversight responsibility for the State Fraud Control Units, the functions of which are investigatory and prosecutorial, is the OIG, the functions of which are investigatory and prosecutorial. Accordingly, the Committee bill directs the Secretary to delegate (or continue to delegate) his administrative responsibilities vis-a-vis the State Medicaid Fraud Control Units to the Inspector General.

COBRA technical corrections and clarifications relating to the Medicaid Program (Sec. 4636)

Section 9506 of COBRA, P.L. 99-272, provides that, for purposes of Medicaid eligibility, the distributions from certain Medicaid qualifying trusts are to be considered available to the individual establishing the trust whether or not actually made. It has come to the Committee's attention that this provision could arguably result in the loss of Medicaid eligibility by about 1200 mentally retarded individuals residing in intermediate care facilities for the mentally retarded (ICFs/MR) in Massachusetts. The Committee is informed that grantor trusts were established for these clients beginning in 1980 to facilitate their eventual return to the community. The potential disqualification of these individuals from Medicaid eligibility was neither foreseen nor intended by the Committee when it first reported this provision as part of H.R. 3101, the Medicare and Medicaid Budget Reconciliation Amendments of 1985. The Committee bill clarifies that section 9506 does not apply to any trust or initial trust decree established prior to April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an ICF/MR.

Section 9517(c) of COBRA clarified that where a Health Insuring Organization (HIO) which has entered into a prepayment contract with a State does anything more than merely process claims for payment, it is subject to the same regulatory requirements as those to which any HMO or prepaid plan is subject under Medicaid law. The provision is effective for HIO's that first become operational

on or after January 1, 1986, subject to the following exception. In the case of those HIO's which first become operational on or after January 1, 1986, but for which the Secretary had granted a 1915(b) waiver before that date, all of the Medicaid regulatory requirements apply except those (1) limiting Medicaid beneficiary enrollment to 75 percent of total enrollment and (2) allowing beneficiaries to disenroll upon 1 month's notice without cause.

On June 27, 1986, the HCFA Administrator notified the State of Pennsylvania that the amendments made by section 9517(c)(2) did not apply to HealthPASS waiver program in Philadelphia. HealthPASS is an HIO that is responsible for the provision of services to approximately 100,000 Medicaid beneficiaries in Philadelphia through arrangements with hospitals, physicians, and other providers of services. According to the General Accounting Office, beneficiary enrollment in HealthPASS began on January 20, 1986, the waiver took effect on February 3, 1986, and services began to be provided through HealthPASS on March 1, 1986. The statutory exception to the January 1, 1986 effective date of section 9517(c) was crafted specifically to accommodate HealthPASS and two other HIO's which had had their section 1915(b) waivers approved but had not begun enrolling patients before January 1, 1986. Nonetheless, HCFA determined that HealthPASS is not subject to section 9517(c), effectively exempting it from basic Medicaid regulatory requirements, including those regarding organizational qualifications, financial and ownership disclosure, quality assurance methods, and actuarial soundness.

HCFA erred. In the view of the Committee, there is no justification for exempting HealthPASS (or the two other HIO's which are protected by the exception clause) from the basic Medicaid regulatory requirements for prepaid plans. These requirements are designed to protect to both the financial integrity of the program and the beneficiaries. The Committee bill therefore clarifies that, for purposes of applying section 9517(c), an HIO is not considered to be operational until the date on which it first enrolls patients. Thus, the amendments made by section 9517(c) apply, and always applied, to HealthPASS. The Committee bill also adds the Hartford Health Network, Inc., to the group of HIO's that is exempt from the requirements (1) limiting Medicaid enrollment to 75 percent and (2) allowing Medicaid beneficiaries to disenroll on one month's notice. As in the case of HealthPASS, the Hartford Health Network is subject to all of the other regulatory requirements applicable to prepaid plans under current law.

Payment for certain long-term care patients in hospitals (Sec. 4637)

Current law provides that a State may reimburse hospitals for inpatient services rendered to Medicaid-eligible patients who no longer need acute hospital care, who do need skilled nursing facility (SNF) care, but for whom such services are unavailable due to shortage of nursing home beds in the community. The rate of payment for such patients awaiting long-term care placement is the estimated State-wide average rate per patient day for SNF services rather than the hospital's inpatient acute care rate, with one exception. The State may choose to pay the higher inpatient hospital rate for such inappropriately-placed patients if there are no excess

beds in the hospital and in the area where the hospital is located. Under HCFA regulations, a hospital or area has excess beds if its occupancy rate is under 80 percent.

The Committee recognizes that reducing hospital capacity will, over time, generate savings in aggregate Medicaid expenditures for hospital services. The Committee believes that, if New York wishes to use the incentive of higher payment rates for long-term care patients to induce hospitals to reduce their bed capacity, the Secretary should have the authority to—and should—allow it to do so, so long as the State's policies have no adverse impact on Federal Medicaid expenditures.

The Committee bill therefore provides that New York, which has substantial excess hospital bed capacity, may pay the inpatient rate for long-term care Medicaid patients in hospitals if either the facility or the region has an occupancy rate of 80 percent or more, but only if the Secretary of HHS determines that a sufficient number of hospital beds have been decertified in the State either on a Statewide or on a regional basis to reduce the aggregate Medicaid payments to hospitals by an amount equal to or greater than the aggregate amount by which Medicaid payments will increase as a result of the higher payment rates for long-term care patients. The Committee believes that, in making this determination, the Secretary should consider that this requirement has been met if a sufficient number of hospital beds has been decertified to ensure that a region has obtained an occupancy of at least 80 percent. Thus, if the Secretary finds that a sufficient number of hospital beds has been decertified in the State, then a hospital could receive a higher payment for patients awaiting long-term care placements if the hospital has an occupancy rate of 80 percent or more, or if the region has an occupancy rate of 80 percent or more.

This provision applies only to New York, which, the Committee understands, has proposed a reimbursement methodology that incorporates these bed decertification incentives. The Committee expects the Secretary to make every effort to accommodate the State's request to implement this provision.

MATERNAL AND CHILD HEALTH

Authorization of additional funds (Sec. 4641)

Under current law, the authorization level for the Maternal and Child Health (MCH) Block Grant (Title V of the Social Security Act) is set at a permanent level of \$478 million. The Committee bill would increase this authorization limit to \$553 million for FY 1987, \$557 million for FY 1988, and \$561 million for FY 1989. In addition, the bill would establish a three-year Federal set-aside within the Block Grant of \$7 million for FY 1987, \$7.5 million for FY 1988, and \$8 million for FY 1989 to provide funds for screening for sickle-cell anemia and other newborn genetic disorders. The monies from this set-aside would revert back into the Block Grant at the end of this three-year period.

Created in 1981, the MCH Block Grant provides funds to the States for the provision of maternal and child health services, including prenatal care, primary health care services for infants and children, and services for children with special health care needs.

Because of the great need and demand for these services, appropriations for the programs have always been set at the maximum amount permitted under the law.

Over the last several years, however, this limitation has proven to be insufficient to meet the ever-growing need for maternal and child health services, especially pregnancy-related services and primary health care services for young children. The unavailability of these services in certain parts of the country has resulted in the continuation of unacceptably high infant mortality rates in those areas. The unavailability of services has also meant that great numbers of children—particularly those from low-income families—still lack access to basic preventive and primary health care services that can help reduce the incidence, severity, and cost of illness and disease later on in life. The Committee bill would alleviate these problems by increasing the funding that could be distributed to the States for maternal and child health services under the Block Grant.

In recognition of the recent work sponsored by the National Institutes of Health (NIH) on the diagnosis and treatment of sickle-cell anemia, the Committee bill would also establish a three-year Federal set-aside for programs to screen for this disease as well as other newborn genetic disorders. According to this study, proper diagnosis and follow-up care during the first few months of life can result in the prevention of most of the almost 200 deaths that occur among black infants with the disease each year. In response to these findings, the NIH study group recommended that all infants at risk of sickle-cell anemia be screened at birth for the disease. Although the report did not make specific findings with respect to the cost-effectiveness of sickle-cell screening programs, the savings that could be achieved from such programs would undoubtedly be significant. The average costs for a sickle-cell screen and follow-up care are approximately \$200, while the costs for treating stroke and other debilitating conditions that can result from this disease are far greater. This conclusion is supported by the work of the General Accounting Office (GAO), which has estimated that screening all infants in the United States for genetic diseases and disorders would save more than \$20 million in treatment costs for every dollar spent on screening.

The three-year Federal set-aside that would be created under the Committee bill would provide the funds that are needed to implement the recommendations of the NIH researchers. Currently, only nine States have developed complete programs for the diagnosis and treatment of sickle-cell anemia; twelve others have some limited screening programs in place. These funds would allow States, and other entities which now lack the resources, to establish or enhance screening programs for sickle-cell anemia and other genetic disorders and diseases. In addition, they would provide the Department of Health and Human Services with the resources to gather and disseminate information and data about the number of children who are afflicted with genetic diseases, their follow-up care and development, and the availability of screening and treatment programs throughout the country.

Maternal and Child Health and Adoption Clearinghouse (Sec. 4642)

The Committee bill would require the Secretary of Health and Human Services to establish a National Adoption Information Clearinghouse which would collect, compile, and maintain data and information on all aspects of infant adoption and adoption of children with special needs. In addition, the Clearinghouse would be responsible for developing, maintaining, and disseminating a directory of information on the various aspects of adoption, including statistical data; State adoption laws; and information on licensed adoption agencies, adoption education and training programs, and centers, shelters, and residences that serve pregnant women. The sole purpose of the National Clearinghouse would be to provide information on adoption to all those who voluntarily seek such information; no services relating to adoption or to other pregnancy options would be offered by or through the Clearinghouse.

HEARINGS

The Committee's Subcommittee on Health and Environment has held 10 hearings on the provisions found in the Committee Print:

On July 17, 1986, the Subcommittee held a hearing on various deficit reduction proposals that would affect Part B of the Medicare program (print not yet available). Testimony was received from 16 witnesses, including representatives of the Administration and several health care organizations and associations whose members would be affected by the proposals.

On May 12, 1986, the Subcommittee held a hearing on the implementation of the National Organ Transplant Act of 1984 (P.L. 98-507) and the recommendations of the Task Force on Organ Transplantation (print not yet available). Testimony was received from 11 witnesses, including members of the Task Force and physicians involved with organ transplantations.

On March 26, 1986, the Subcommittee held a hearing on the financial burden of health care on the elderly (print not yet available). Testimony was received from 4 witnesses, including the Congressional Budget Office and researchers in the area of health care financing for the elderly.

On March 5, 1986, the Subcommittee held a hearing on the financing of Non-Hospital Care for Individuals with Acquired Immune Deficiency Syndrome (AIDS) (print not yet available). Testimony was received from 6 witnesses, including the Administration, families of AIDS patients, and representatives of organizations that are providing non-hospital care to AIDS patients and that are studying the costs of such care.

On January 27, 1986, the Subcommittee held a field hearing in Palm Harbor, Florida on Alzheimer's disease and related disorders (Ser. No. 99-71). Testimony was received from 18 witnesses and was submitted for the record by 1 individual. Witnesses included families of Alzheimer's patients and representatives of organizations that provide service to both Alzheimer's patients and their families.

On November 1, 1985, the Subcommittee held a hearing on the cost of treatment for Acquired Immune Deficiency (AIDS) and the question of who is going to pay those costs (Ser. No. 99-45). Testi-

mony was received from 12 witnesses and was submitted for the record by 2 Members of the House of Representatives. Witnesses included representatives of the Administration, associations whose members pay for AIDS-related services, and institutions which provide care to AIDS patients.

On July 22, 1985, the Subcommittee held a hearing on research and treatment of Acquired Immune Deficiency (AIDS) (Ser. No. 99-45). Testimony was received from 8 witnesses and was submitted for the record by 1 individual. Witnesses included representatives of the Administration and institutions that provide treatment services to AIDS patients.

On July 17, 1985, the Subcommittee held a hearing on various deficit reduction proposals that would affect Part B of the Medicare program (Ser. No. 99-265 [Part 1]). Testimony was received from 16 witnesses including representatives of the Administration and several health care organizations and associations whose members would be affected by the proposals.

On April 3, 1985, the Subcommittee held a hearing on Medicare and Medicaid support for medical education (Ser. No. 99-19). Testimony was received from 15 witnesses, including various agencies and organizations that are involved with medical education and the training of physicians.

On January 27, 1984, the Subcommittee held a field hearing on Medicare vision care reform in Baltimore, Maryland (Ser. No. 98-141). Testimony was received from 9 witnesses and was submitted for the record by 3 organizations. Witnesses included representatives from organizations that are involved with the provision of vision care.

COMMITTEE CONSIDERATION

On July 23, 1986, the Committee met in open session and, by voice vote, a quorum being present, ordered transmitted to the Committee on the Budget, a Committee print, as amended, containing amendments relating to Medicare, Medicaid, and the Maternal and Child Health Block Grant program, in accordance with section 310 of the Congressional Budget Act.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(1)(3)(A) of Rule XI of the rules of the House of Representatives, the Committee made oversight findings that are reflected in this legislative report.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that the amendments made by this Print will reduce budget outlays for fiscal years 1987, 1988, and 1989, by an amount in excess of that estimated by the Congressional Budget Office. The Committee notes that, according to CBO, this bill would reduce Federal Medicare outlays by a total of \$1.083 billion over the next three years.

The Committee takes exception to the CBO estimate that section 4601 of the Print, relating to the expansion of Medicaid coverage

for pregnant women and infants up to age 1 with incomes below the Federal poverty line, will decrease Federal outlays by \$175 million over the next three years. It is the Committee's understanding that CBO did not adjust for the savings in reduced intensive care and long-term institutional costs that can reasonably be expected from the reduction in the incidence of low birthweight births among the target population that greater access to prenatal care should produce. These savings have been conservatively estimated to be in the range of \$3 for every \$1 invested in prenatal care for this disadvantaged, high-risk population. The Committee to Study the Prevention of Low Birthweight of the Institute of Medicine of the National Academy of Sciences, "Preventing Low Birthweight" (1985), at 212-237. In the Committee's view, its proposal may well initially result in net outlays, but these costs will in subsequent years be more than offset by savings of the magnitude estimated by the IOM Committee.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC., July 28, 1986.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimates of the provisions in Subtitles F and G in the House Committee on Energy and Commerce reconciliation package. The estimates show both budget authority and outlays effects.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,
Sincerely,

RUDOLPH G. PENNER, *Director.*

PRELIMINARY SUBTITLE F AND G ENERGY AND COMMERCE RECONCILIATION PROVISIONS IN
MILLIONS OF DOLLARS

Sections	Fiscal year—			3-year total
	1987	1988	1989	
SUBTITLE F—MEDICARE PROVISIONS				
Part 1—Provisions Relating to Parts A and B				
4501—Direct costs of graduate medical education:				
Budget authority	0	0	0	0
Outlays	0	0	—6	—6
4502—Payment limits for home health services:				
Budget authority	0	—5	—5	—10
Outlays	30	15	20	65
4503—Establishment of research program:				
Budget authority	3	4	4	11
Outlays	6	7	8	21
4504—Group purchasing vendor agreements:				
Budget authority	0	0	0	0
Outlays	0	0	0	0
4505—Civil monetary penalties:				
Budget authority	0	0	0	0
Outlays	0	0	0	0

PRELIMINARY SUBTITLE F AND G ENERGY AND COMMERCE RECONCILIATION PROVISIONS IN
MILLIONS OF DOLLARS—Continued

Sections	Fiscal year—			3-year total
	1987	1988	1989	
4506—Payment rates for ESRD services (contains cyclosporin):				
Budget authority.....	—75	—66	—66	—207
Outlays.....	—75	—65	—65	—205
4507—ESRD Network Program Administration:				
Budget authority.....	0	0	0	0
Outlays.....	0	0	0	0
4508—Organ transplant protocols and standards:				
Budget authority.....	0	0	0	0
Outlays.....	0	0	0	0
4509—COBRA technical corrections:				
Budget authority.....	0	0	0	0
Outlays.....	0	0	0	0
4510—50 percent Nonmedicare enrollment for HMO's and CMP's:				
Budget authority.....	0	0	0	0
Outlays.....	0	0	0	0
Subtotal for part 1:				
Budget authority.....	—72	—67	—67	—206
Outlays.....	—39	—43	—43	—125
Part 2—Provisions Relating to Part B				
4521—Coverage of vision care:				
Budget authority.....	37	62	72	171
Outlays.....	35	60	70	165
4522—Coverage of occupational therapy:				
Budget authority.....	16	16	20	52
Outlays.....	15	15	20	50
4523—Physician assistant services:				
Budget authority.....	0	0	0	0
Outlays.....	0	0	0	0
4524—Nurse anesthetists services:				
Budget authority.....	0	0	0	0
Outlays.....	0	0	0	0
4525—Payment for physician services:				
Budget authority.....	0	—80	—105	—185
Outlays.....	0	—70	—105	—175
4526—Inherent reasonableness authority:				
Budget authority.....	0	0	0	0
Outlays.....	0	0	0	0
4527—Payment for cataract surgery:				
Budget authority.....	—170	—230	—260	—660
Outlays.....	—150	—220	—245	—615
4528—Payment for clinical lab tests:				
Budget authority.....	—20	—75	—95	—190
Outlays.....	—10	—70	—90	—170
4529—Payment for parenteral and enteral nutrition supplies:				
Budget authority.....	—37	—37	—42	—116
Outlays.....	—35	—35	—40	—110
4530—Payment for oxygen therapy services:				
Budget authority.....	—43	—64	—68	—175
Outlays.....	—40	—60	—65	—165
4531—Physician Payment Review Commission:				
Budget authority.....	0	0	0	0
Outlays.....	0	0	0	0
4532—Changing Medicare appeal rights:				
Budget authority.....	5	10	10	25
Outlays.....	4	8	8	20

PRELIMINARY SUBTITLE F AND G ENERGY AND COMMERCE RECONCILIATION PROVISIONS IN
MILLIONS OF DOLLARS—Continued

Sections	Fiscal year—			3-year total
	1987	1988	1989	
4533—Alzheimer's demonstrations:				
Budget authority	14	14	14	42
Outlays	14	14	14	42
Subtotal for part 2:				
Budget authority	—198	—384	—454	—1,036
Outlays	—167	—358	—433	—958
Subtotal for Subtitle F:				
Budget authority	—270	—451	—521	—1,242
Outlays	—206	—401	—476	—1,083
4601—Poor pregnant women and infants optional coverage:				
Budget authority	15	75	85	175
Outlays	15	75	85	175
4602—Elderly and disabled poor, all Medicaid benefits:				
Budget authority	30	100	140	270
Outlays	30	100	140	270
4603—Poor Medicare beneficiaries, Medicare cost-sharing expenses:				
Budget authority	15	70	100	185
Outlays	15	70	100	185
4621—Hold-harmless provision for med assistance percent for Medicaid:				
Budget authority	50	0	0	50
Outlays	50	0	0	50
4631—Contracts for quality review of HMO's:				
Budget authority	(¹)	(¹)	(¹)	(¹)
Outlays	(¹)	(¹)	(¹)	(¹)
Subtotal for subtitle G:				
Budget authority	110	245	325	680
Outlays	110	245	325	680
Total for subtitles F and G direct spending:				
Budget authority	—160	—206	—196	—562
Outlays	—96	—156	—151	—403
Authorizations				
4641—Authorization of funds, maternal and child health:				
Authorization	75	79	83	237
Outlay	42	68	78	188
4642—National maternal and child health clearinghouse:				
Authorization	(¹)	(¹)	(¹)	(¹)
Outlay	(¹)	(¹)	(¹)	(¹)
Total for subtitles F and G authorizations:				
Authorization	75	79	83	237
Outlay	42	68	78	188
Total for subtitles F and G:				
Budget authority/authorization	—85	—127	—113	—325
Outlay	—54	—88	—73	—215

¹ Effect of provision is less than \$500,000.

INFLATION IMPACT STATEMENT

Pursuant to clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the Committee states that the bill as reported will have no inflationary impact, but instead will contribute to a reduction in inflationary pressures by lowering projected Federal spending for medical care.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * *

TITLE XI—GENERAL PROVISIONS AND PEER REVIEW

TABLE OF CONTENTS OF TITLE

PART A—GENERAL PROVISIONS

* * * * *

EXCLUSION OF CERTAIN INDIVIDUALS CONVICTED OF MEDICARE- OR
MEDCAID-RELATED CRIMES

SEC. 1128. (a) * * *

* * * * *

(f) *For purposes of subsection (a), a physician or other individual is considered to have been convicted of a criminal offense—*

(1) when a judgment of conviction has been entered against the physician or individual by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;

(2) when there has been a finding of guilt against the physician or individual by a Federal, State, or local court;

(3) when a plea of guilty or nolo contendere by the physician or individual has been accepted by a Federal, State, or local court; and

(4) when the physician or individual has entered into participation in a first offender or other program where judgment of conviction has been withheld.

CIVIL MONETARY PENALTIES

SEC. 1128A. (a) Any person (including an organization, agency, or other entity) that—

(1) * * *

* * * * *

(3) *In a proceeding under subsection (a) which—*

(A) is against an individual who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal crime charging fraud or false statements, and

*(B) involves the same transaction as in the criminal action,
the individual is estopped from denying the essential elements of the criminal offense.*

(4) *The official conducting a hearing under this section may sanction a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an action, or other misconduct as would interfere with the speedy, orderly, or fair conduct of the hearing. Such sanction shall reasonably relate to the severity and nature of the failure or misconduct. Such sanction may include—*

(A) in the case of refusal to provide or permit discovery, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established,

(B) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense,

(C) striking pleadings, in whole or in part,

(D) staying the proceedings,

(E) dismissal of the action,

(F) entering a default judgment,

(G) ordering the party or attorney to pay attorneys' fees and other costs caused by the failure or misconduct, and

(H) refusing to consider any motion or other action which is not filed in a timely manner.

* * * * *

HOSPITAL PROTOCOLS FOR ORGAN PROCUREMENT AND STANDARDS FOR ORGAN PROCUREMENT AGENCIES

SEC. 1138. (a) The Secretary shall provide that no hospital may participate in the programs under title XVIII and XIX unless the hospital establishes protocols for encouraging organ and tissue donation by identifying and assisting potential human organ and tissue donors in a manner that (1) assures that families of potential donors are made aware of the option of organ or tissue donation and their option to decline, and (2) encourages discretion and sensitivity to the circumstances, views, and beliefs of families.

(b) The Secretary shall provide that no payment may be made under title XVIII or XIX with respect to costs in procuring organs attributable to payments made to an organ procurement agency which—

(1) is not a qualified organ procurement organization (described in section 371(b) of the Public Health Service Act) or meets the standards to be such an organization, and

(2) has not been certified (and recertified not less often than once every two years) as meeting the standards for certification of organ procurement agencies established by the Association of Independent Organ Procurement Agencies.

* * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE
AGED AND DISABLED

* * * * *

SCOPE OF BENEFITS

SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph (2); and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) home health services;

(B) medical and other health services furnished by a provider of services or by others under arrangement with them made by a provider of services, excluding—

(i) physician services except where furnished by—

(I) a resident or intern of a hospital, or

(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital) where the conditions specified in paragraph (7) of such section are met,
[and]

(ii) services for which payment may be made pursuant to section 1835(b)(2); [and], and

(iii) *services of a registered nurse anesthetist; and*

[(C) outpatient physical therapy services, other than services to which the next to last sentence of section 1861(p) applies;]

(C) outpatient physical therapy services (other than services to which the second sentence of section 1861(p) applies) and outpatient occupational therapy services (other than services to which such sentence applies through the operation of section 1861(g));

* * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)–80 percent of the reasonable charges for the services; except that

(A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment

basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section 1861(s)(10)(A), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule under subsection (h)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on the basis of an assignment described in section 1842(b)(3)(B)(ii), under the procedure described in section 1870(f)(1), or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion) of the lesser of the amount determined under such fee schedule; the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate, (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, (F) with respect to expenses incurred for services described in subsection (i)(3) under the conditions specified in such subsection, the amounts paid shall be the reasonable charge for such services, [and] (G) with respect to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), the amounts paid shall be 100 percent of the reasonable charges for such items and services; (H) with respect to services of a registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the reasonable charges for such services established by the Secretary in accordance with subsection (1), and (I) with respect to oxygen therapy services (as defined in subsection (m)(6)), the amount paid shall be equal to 80 percent of the amount determined under the monthly prospective fee schedule under subsection (1),

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (D), (E), and (F) of such section and unless otherwise specified in section 1881)—

(A) * * *

* * * * *

(B) with respect to other items and services (except those described in subparagraph (C) [or (D)] *(D)*, or *(E)* of this paragraph and except as may be provided in section 1886)—

(i) the lesser of—

(I) the reasonable cost of such services, as determined under section 1861(v), or

(II) the customary charges with respect to such services,

less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such other services exceed 80 percent of such reasonable cost, or

(ii) if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, 80 percent of the amount determined in accordance with section 1814(b)(2), or

(iii) if (and for so long as) the conditions described in section 1814(b)(3) are met, the amounts determined under the reimbursement system described in such section,

(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services; [and]

(D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule determined under subsection (h)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on the basis of an assignment described in section 1842(b)(3)(B)(ii), under the procedure described in section 1870(f)(1), or to a provider having an agreement under section 1866) of the lesser of the amount determined under such fee schedule or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate for such rates; and

(E) with respect to oxygen therapy services, 80 percent of the amount determined under the monthly prospective fee schedule under subsection (n);

* * * * *

(g) In the case of services described in the [next to last] *second* sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than \$500 shall be considered as incurred expenses for purposes of subsections (a) and (b). *In the case of outpatient occupational therapy services which are described in*

the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year, no more than \$500 shall be considered as incurred expenses for purposes of subsections (a) and (b).

(h)(1)(A) The Secretary shall establish fee schedules for clinical diagnostic laboratory tests for which payment is made under this part, other than such tests performed by a provider of services for an inpatient of such provider.

(B) In the case of clinical diagnostic laboratory tests performed by a physician or a laboratory [(other than tests performed by a hospital laboratory for outpatients of such hospital)], the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished [during the period beginning on July 1, 1984, and ending on June 30, 1987. For such tests furnished on or after July 1, 1987, the fee schedule shall be established on a nationwide basis.] *on or after July 1, 1984.*

[(C) In the case of clinical diagnostic laboratory tests performed by a hospital laboratory for outpatients of such hospital, the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished during the period beginning on July 1, 1984, and ending on June 30, 1987. For such tests furnished on or after July 1, 1987, the fee schedule under subparagraph (A) shall not apply with respect to clinical diagnostic laboratory tests performed by a hospital laboratory for outpatients of such hospital.]

(2) except as provided in paragraph (4), the Secretary shall set the fee schedules at 60 percent [(or, in the case of a test performed by a hospital laboratory for outpatients of such hospital, 62 percent)] of the prevailing charge level determined pursuant to the third and fourth sentences of section 1842(b)(3) for similar clinical diagnostic laboratory tests for the applicable region, State, or area (or, effective December 31, 1987, for the United States) for the 12-month period beginning July 1, 1984, adjusted annually (to become effective on January 1 of each year) by a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average), and subject to such other adjustments as the Secretary determines are justified by technological changes. The Secretary may make further adjustments or exceptions to the fee schedules to assure adequate reimbursement of (A) emergency laboratory tests needed for the provision of bona fide emergency services, and (B) certain low volume high-cost tests where highly sophisticated equipment or extremely skilled personnel are necessary to assure quality.

(3) In addition to the amounts provided under the fee schedules, the Secretary shall provide for and establish (A) a nominal fee to cover the appropriate costs in collecting the sample on which a clinical diagnostic laboratory test was performed and for which payment is made under this part, except that not more than one such fee may be provided under this paragraph with respect to samples collected in the same encounter, and (B) *a fee to cover the*

transportation and personnel expenses for trained personnel to travel to the location of an individual to collect the sample, except that such a fee may be provided only with respect to an individual who is homebound or an inpatient in an inpatient facility (other than a hospital).

* * * * *

(1)(1) With respect to services of a registered nurse anesthetist under section 1861(s)(11), the reasonable charge shall be an amount determined by the Secretary to be consistent with efficient and high quality anesthesia services, taking into account the prevailing rate for such services, but modified to the extent necessary to comply with the requirements of paragraph (2).

(2) In establishing the reasonable charge for those services, the Secretary shall adjust the reasonable charge to the extent necessary to ensure that the total amount which will be paid under this title for those services in any fiscal year (as estimated by the Secretary) will not exceed the total amount which would be paid under this title for those services in the fiscal year if the services were included as inpatient hospital services and payment for such services was made under part A in the same manner as payment was made in fiscal year 1986, adjusted to take into account changes in prices and technology relating to the administration of anesthesia.

(3) In establishing the reasonable charge for medical direction of services of a registered nurse anesthetist under section 1861(s)(11), the Secretary shall adjust the reasonable charge to the extent necessary to ensure that the total amount which will be paid under this title for such medical direction and such services in any fiscal year (as estimated by the Secretary) will not exceed the total amount which would have been paid but for the enactment of the amendments made by section 4524 of the Budget Reconciliation Act of 1986.

(4)(A) If an adjustment under paragraph (3) results in a reduction in the reasonable charge for a physicians' service and a nonparticipating physician furnishes the service to an individual entitled to benefits under this part—

(i) the physician may not charge the individual more than 125 percent of the adjusted prevailing charge for the service, and

(ii) if the physician charges more than such amount, the physician shall refund to the individual (and shall be liable to the individual for) any amounts received in excess of such amount.

(B) If a physician knowingly and willfully imposes charges or fails to make refunds in violation of subparagraph (A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(M)(1) The Secretary shall establish monthly capitation fee schedules, on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for oxygen therapy services for which payment is made under this part.

(2)(A) Under each such schedule, payment shall be made under this part on the basis of the number of units of oxygen prescribed for a patient per month without regard to the actual number of units of oxygen so used.

(B) The Secretary shall require verification of the initial prescription requirements and any subsequent changes therein by laboratory data or such other means deemed appropriate by the Secretary.

(C) No payment may be made under this part for oxygen therapy services (i) other than to a provider of services with an agreement in effect under section 1866 or on an assignment-related basis (as defined in section 1842(i)(8)) or (ii) furnished more than one year after the date of the prescription for such services.

(D) No payment may be made under this part for oxygen therapy services furnished pursuant to a prescription of a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, the entity furnishing the oxygen therapy services, except that this prohibition shall not apply with respect to an entity which is the sole supplier (as determined by the Secretary) of oxygen therapy services in a community.

(E) With respect to payment for oxygen therapy services, the Secretary shall provide that—

(i) if payment is not made on or before the 22nd calendar day after the date on which a clean claim is received, interest on the claim shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made;

(ii) within 22 calendar days after the date a claim for payment under this part is received, the carrier shall notify the entity submitting the claim of any defect or impropriety in the claim (including the lack of any required substantiating documentation) or circumstance requiring special treatment that prevents the claim from being treated as a clean claim and prevents timely payment from being made;

(iii) if notice required under clause (ii) is not provided on a timely basis with respect to a claim and payment is subsequently made on the claim, interest on the amount determined to be payable shall be made (at the rate described in clause (i)) for the period beginning on the day after the required notice date and ending on the date on which payment is made or the date the notice is provided, whichever date is earlier; and

(iv) the carrier will be reimbursed for the amount of interest paid under this subparagraph from amounts made available for Federal administrative costs to carry out this part.

In this subparagraph, the term "clean claim" means a claim which meets the requirements of this title for payment under this part and the term "carrier" refers to the appropriate carrier with a contract under section 1842.

(3) Subject to paragraph (4), the Secretary shall set such fee schedules at 100 percent of the reasonable charge level determined (pursuant to section 1842(b)(3)) for the 12-month period ending June 30, 1986, for oxygen therapy services (excluding any part of such charges relating to the purchase or rental of equipment) furnished in the applicable region, State, or area. Such fee schedules shall be adjusted annually (to become effective January 1 of each year, beginning with 1987) by a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Con-

sumers (all items; United States city average), and subject to such other adjustments as the Secretary determines are justified by technological changes. The Secretary shall also base such fee schedule on the lowest cost medically appropriate means of delivery.

(4) The Secretary shall provide for a percentage increase (established by the Secretary) in the fee schedule amounts for oxygen therapy services furnished through a portable device. In order to assure the availability of oxygen therapy services for individuals consuming small amounts of oxygen, the Secretary shall provide for a minimum monthly amount for the furnishing of oxygen therapy services.

(5) Nothing in this subsection shall be construed as requiring the use of any particular type of equipment or device.

(6) In this subsection and subsection (a), "oxygen therapy services" means durable medical equipment, accessories, and supplies for the provision of oxygen therapy in a patient's home.

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year; and

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needs or needed skilled nursing care on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(B) in the case of medical and other health services except services described in subparagraphs (B), (C), and (D),

or section 1861(s)(2), such services are or were medically required;

(C) in the case of outpatient physical therapy services or *outpatient occupational therapy services*, (i) such services are or were required because the individual needed physical therapy services or *occupational therapy services, respectively*, (ii) a plan for furnishing such services has been established by a physician or by the qualified physical therapist or *qualified occupational therapist, respectively*, providing such services and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(D) in the case of outpatient speech pathology services, (i) such services are or were required because the individual needed speech pathology services, (ii) a plan for furnishing such services has been established by a physician or by the speech pathologist providing such services and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician; and

(E) in the case of comprehensive outpatient rehabilitation facility services, (i) such services are or were required because the individual needed skilled rehabilitation services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician.

For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) *(or meets the requirements of such section through the operation of section 1861(g))*, or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) *or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services.*

* * * * *

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

* * * * *

(b)(1) * * *

* * * * *

(3) Each such contract shall provide that the carrier—

(A) * * *

* * * * *

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an op-

portunity for a fair hearing by the carrier, in any case where the amount in controversy is **[\$100 or more]** *at least \$100, but not more than \$500*, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

* * * * *

(F) will take such action as may be necessary to assure that where payment under this part for a service rendered is on a charge basis, such payment shall be determined on the basis of the charge that is determined in accordance with this section on the basis of customary and prevailing charge levels in effect at the time the service was rendered or, in the case of services rendered more than 12 months before the year (ending on September 30) in which the bill is submitted or request for payment is made, on the basis of such levels in effect for the 12-month period preceding such year; and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the 12-month period ending on the March 31 last preceding the start of the twelve-month period (beginning October 1 of each year) in which the service is rendered. In the case of physician services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any twelve-month period (beginning after June 30, 1973) specified in clause (ii) of such sentence may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. With respect to power-operated wheelchairs for which payment may be made in accordance with section 1861(s)(6), charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The require-

ment in subparagraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (I) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health and Human Services performing functions under this title and acting within the scope of his or its authority, and (II) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected. Notwithstanding the provisions of the third and fourth sentences preceding this sentence, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such third and fourth sentences for the twelve-month period beginning on October 1 in any calendar year after 1974 shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1985. The amount of any charges for outpatient services which shall be considered reasonable shall be subject to the limitations established by regulations issued by the Secretary pursuant to section 1861(v)(1)(K), and in determining the reasonable charge for such services, the Secretary may limit such reasonable charge to a percentage of the amount of the prevailing charge for similar services furnished in a physician's office, taking into account the extent to which overhead costs associated with such outpatient services have been included in the reasonable cost or charge of the facility. *With respect to services described in section 1861(s)(2)(K) (relating to a physician assistant acting under the supervision of a physician), the prevailing charges shall not exceed 90 percent of the prevailing charges applicable with respect to the physician's performance of the services.*

(4)(A)(i) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 15-month period beginning July 1, 1984, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

(ii)(I) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

(II) In determining the prevailing charge levels under the fourth sentence of paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall permit an additional one percentage point increase in the increase otherwise permitted under that sentence.

(III) In determining the prevailing charge levels under the fourth sentence of paragraph (3) for physicians' services furnished on or after January 1, 1987, by a participating physician, the Secretary

shall treat the additional 1 percent increase permitted on May 1, 1986, under subclause (II), as having been justified by economic changes.

(iii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during a 12-month period beginning on or after January 1, 1987, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for services during the previous calendar year (without regard to clause (ii)(II)) for physicians who were participating physicians during that year.

(iv) For physicians' services furnished on or after January 1, 1987, for which payment is not made on an assignment-related basis, for purposes of the fourth sentence of paragraph (3), the increase that is justified under the index described in that sentence for 1987 is 1 percent.

(D)(i) In determining the customary charges for physicians' services furnished during the 8-month period beginning May 1, 1986, or the 12-month period beginning January 1, 1987, by a physician who was not a participating physician (as defined in subsection (h)(1)) on September 30, 1985, the Secretary shall not recognize increases in actual charges for services furnished during the 15-month period beginning on July 1, 1984, above the level of the physician's actual charges billed in the 3-month period ending on June 30, 1984.

(ii) In determining the customary charges for physicians' services furnished during the 12-month period beginning January 1, 1987, by a physician who is not a participating physician (as defined in subsection (h)(1)) on April 30, 1986, the Secretary shall not recognize increases in actual charges for services furnished during the 7-month period beginning on October 1, 1985, above the level of the physician's actual charges billed in the 3-month period ending on June 30, 1984.

(iii) In determining the customary charges for physicians' services furnished during the 12-month period beginning January 1, 1987, or January 1, 1988, by a physician who is not a participating physician (as defined in subsection (h)(1)) on December 31, 1986, the Secretary shall not recognize increases in actual charges for services furnished during the 8-month period beginning on May 1, 1986, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984.

(iv) In determining the customary charges for physicians' services furnished during 1988 and 1989 by a physician, if the physician was a nonparticipating physician in 1987, the Secretary shall not recognize any amount of such charges in 1987 that exceed the limit imposed under subsection (j)(1)(C).

* * * * *

(6) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that (A) payment may be made [(A)(i)] (i) to the employer of such physician or other person

if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (ii) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service, **[or]** (B) *payment may be made* (B) to an entity (i) which provides coverage of the services under a health benefits plan, but only to the extent that payment is not made under this part, (ii) which has paid the person who provided the service an amount (including the amount payable under this part) which that person has accepted as payment in full for the service, and (iii) to which the individual has agreed in writing that payment may be made under this part. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment, and (C) *in the case of services described in section 1861(s)(2)(K) where payment is made on an assignment-related basis, payment shall be made to the employer of the physician assistant involved.*

* * * * *

(8) (A) The Secretary by regulation shall—

[(A)] (i) describe the factors to be used in determining the cases (of particular items or services) in which the application of this subsection results in the determination of a reasonable charge that, by reason of its grossly excessive or grossly deficient amount, is not inherently reasonable, and

[(B)] (ii) provide in those cases for the factors that will be considered in establishing a reasonable charge that is realistic and equitable.

(B) The Secretary may provide for an increase or decrease in the reasonable charge otherwise recognized under this section with respect to a specific physicians' service, if the Secretary has made specific findings with respect to that service in accordance with the criteria set forth in subparagraph (A) and with the succeeding provisions of this paragraph.

(C)(i) In applying subparagraph (A), the Secretary may compare—
 (I) the charges and resource costs for related procedures,
 (II) charges and resource costs for the procedure over a period of time,
 (III) charges for a procedure in different geographic areas,
 and

(IV) the charges and allowed payments for a procedure under this part and by other payors.

(ii) An adjustment under subparagraph (B) on the basis of a comparison of the prevailing charges in different localities may be made only if the Secretary determines that the prevailing charge allowed in one locality is grossly out of line with prevailing charges allowed in other localities after accounting for differences in practice costs.

(iii) In this subparagraph, “resource costs” include factors such as the time required to provide a procedure (including pre-procedure evaluation and post-procedure followup), the complexity of the procedure, the training required to perform the procedure, and the risk involved in the procedure.

(D) In determining whether to adjust payment rates under subparagraph (B), the Secretary shall consider—

(i) the potential impacts on quality, access, and beneficiary liability of the adjustment,

(ii) likely effects on assignment rates, reasonable charge reductions on unassigned claims, and participation rates of physicians,

(iii) the proportion of such procedures for which payment is available under this part, and

(iv) the prevailing charges of other third-party payors for the procedure.

(E)(i) Before making an adjustment under subparagraph (B), the Secretary shall—

(I) publish notice of the proposed adjustment, which shall contain a summary of the study data and an explanation of the basis for the proposed adjustment, and

(II) provide a period of at least 60 days during which interested parties may comment on the proposed adjustment.

(ii) Before publishing a notice of proposed adjustment under clause (i)(I), the Secretary shall consult with the Physician Payment Review Commission and shall provide the Commission an opportunity to review and comment on the proposal.

(iii) An adjustment under subparagraph (B) shall only take effect only after publication of a final notice by the Secretary. In such notice the Secretary shall explain the factors and data that were taken into consideration in making the adjustment and shall respond to any comments made by the Physician Payment Review Commission.

(F)(i) If an adjustment under subparagraph (B) results in a reduction in the reasonable charge for a physicians’ service and a nonparticipating physician furnishes the service to an individual entitled to benefits under this part—

(I) the physician may not charge the individual more than 125 percent of the adjusted prevailing charge for the service, and

(II) if the physician charges more than such amount, the physician shall refund to the individual (and shall be liable to the individual for) any amounts received in excess of such amount.

(ii) If a physician knowingly and willfully imposes charges or fails to make refunds in violation of subparagraph (A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(9)(A) In providing payment for cataract eyeglasses and cataract contact lenses, and professional services relating to them, under this part, each carrier shall—

(A) provide for separate determinations of the payment amount for the eyeglasses and lenses and of the payment amount for the professional services of a physician (as defined in section 186(r)), and

(B) not recognize as reasonable for such eyeglasses and lenses more than such amount as the Secretary establishes in guidelines relating to the inherent reasonableness of charges for such eyeglasses and lenses.

(E) In determining the reasonable charge under paragraph (3) for cataract surgery with intraocular lens implantation, the prevailing charge for such surgery shall not be recognized to the extent it exceeds 110 percent of the prevailing charge recognized for such surgery without intraocular lens implantation.

(C) In determining the reasonable charge under paragraph (3) for cataract surgery anesthesia, the Secretary shall not recognize more than 4 base units (as used for purposes of determining payment for anesthesia services as of the date of the enactment of this subparagraph) or equivalent amounts.

* * * * *

(h)(1) Any physician or supplier may voluntarily enter into an agreement with the Secretary to become a participating physician or supplier. For purposes of this section, the term “participating physician or supplier” means a physician or supplier (excluding any provider of services) who, before the beginning of any year beginning with 1984, enters into an agreement with the Secretary which provides that such physician or supplier will accept payment under this part on an assignment for all items and services furnished to individuals enrolled under this part during such year. In the case of a newly licensed physician or a physician who begins a practice in a new area, or in the case of a new supplier who begins a new business, or in such similar cases as the Secretary may specify, such physician or supplier may enter into such an agreement after the beginning of a year, for items and services furnished during the remainder of the year. *For purposes of this section, the term “participating physician” refers, with respect to the furnishing of services, to a physician who at the time of furnishing the services is a participating physician, and the term “nonparticipating physician” refers, with respect to the furnishing of services, a physician who at the time of furnishing the services is not a participating physician.*

* * * * *

(3) The Secretary shall promptly notify individuals enrolled under this part of the publication of [such] the directories and shall make [such] the appropriate area directory or directories available in each district and branch office of the Social Security Administration, in the offices of carriers, and to senior citizen organizations.

(4) The Secretary shall provide that the [the] directories shall be available for purchase by the public.

(j)(1) (A) *In the case of a physician who is not a participating physician for items and services furnished during a portion of the 30-month period beginning July 1, 1984, the Secretary shall monitor the physician's actual charges to individuals enrolled under this part for physicians' services during that portion of that period. If such physician knowingly and willfully bills individuals enrolled under this part for actual charges in excess of such physician's actual charges for the calendar quarter beginning on April 1, 1984, the Secretary may apply sanctions against such physician in accordance with paragraph (2).*

(B) *In the case of a nonparticipating physician for services furnished on or after January 1, 1987, the Secretary shall monitor the physician's actual charges for such services. If such physician knowingly and willfully bills for actual charges in excess of the charges permitted under subparagraph (C), the Secretary may apply sanctions against such physician in accordance with paragraph (2).*

(C) *With respect to services furnished during 1987 for which payment is—*

(i) made on an assignment-related basis, the charges may not exceed the physician's actual charges for the calendar quarter beginning on April 1, 1984, increased by the percentage increase in the medical economic index (under the fourth sentence of paragraph (3)) applicable to physicians' services furnished as of January 1, 1987, or

(ii) not made on an assignment-related basis, the charges may not exceed the physician's actual charges for the calendar quarter beginning on April 1, 1984, increased by 1 percent.

(2) Subject to paragraph (3), the sanctions which the Secretary may apply under paragraph (1) or subsection (b)(8)(F), (k), (1), or (1)(m), or (n) or section 1833(l)(4) are—

(A) barring a physician from participation under the program under this title for a period not to exceed 5 years, in accordance with the procedures of paragraphs (2) and (3) of section 1862(d), or

(B) the imposition of civil monetary penalties and assessments, in the same manner as such penalties are authorized under section 1128A(a),

or both. No payment may be made under this title with respect to any item or service furnished by a physician during the period when he is barred from participation in the program under this title pursuant to this subsection.

* * * * *

(k)(1) If a physician knowingly and willfully *presents or causes to be presented a claim or bills* an individual enrolled under this part for charges for services as an assistant at surgery for which pay-

ment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(2) If a physician knowingly and willfully *presents or causes to be presented a claim or bills* an individual enrolled under this part for charges that includes a charge for an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(l)(1) With respect to the provision of cataract surgery with intraocular lens implantation and cataract surgery anesthesia furnished by a nonparticipating physician to an individual entitled to benefits under this part—

(A) the physician may not charge the individual more than 125 percent of the prevailing charge recognized under this part for the services (which, in the case of cataract surgery anesthesia, is based on conversion factors taking into account the base and time units allowed), and

(B) if the physician charges more than such amount, the physician shall refund to the individual (and shall be liable to the individual for) any amounts received in excess of such amount.

(2) If a physician knowingly and willfully imposes charges or fails to make refunds in violation of paragraph (1), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

* * * * *

PHYSICIAN PAYMENT REVIEW COMMISSION

SEC. 1845. (a)(1) The Director of the Congressional Office of Technology Assessment (hereinafter in this section referred to as the "Director" and the "Office", respectively) shall provide for the appointment of a Physician Payment Review Commission (hereinafter in this section referred to as the "Commission"), to be composed of individuals with expertise in the provision and financing of physicians' services appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service).

(2) The Commission shall consist of **[11]** 13 individuals. Members of the Commission shall first be appointed no later than May 1, 1986, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than four members expire in any one year.

* * * * *

PART C—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * *

Inpatient Hospital Services

(b) The term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) * * *

* * * * *

(4) medical or surgical services provided by a physician, resident, or intern, *costs of anesthesia services provided by a certified registered nurse anesthetist*; and

* * * * *

Outpatient Occupational Therapy Services

(g) The term "outpatient occupational therapy services" has the meaning given the term "outpatient physical therapy services" in subsection (p), except that "occupational" shall be substituted for "physical" each place it appears therein.

* * * * *

Physician

(r) The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine for the purposes of subsection (s) of this section but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them; and for the purposes of subsections (k), (m), and (p)(1) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only if his performance of functions under subsections (k), (m), and (p)(1) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 is consistent with the policy of the institution or agency with respect to which he performs them and with the functions which he is legally authorized to perform, [(4) a doctor of optometry who is legally authorized to practice optometry by the State in which he performs such action, but only with respect to services related to the condition of aphakia, or] (4) a doctor of optometry, but only with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is

legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) * * *

* * * * *

(D) outpatient physical therapy services *and outpatient occupational therapy services*;

* * * * *

(H)(i) services furnished pursuant to a contract under section 1876 to a member of an eligible organization by a physician assistant or by a nurse practitioner (as defined in subsection (aa)(3)) and such services and supplies furnished as an incident to his service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service; and

(ii) services furnished pursuant to a risk-sharing contract under section 1876(g) to a member of an eligible organization by a clinical psychologist (as defined by the Secretary), and such services and supplies furnished as an incident to his services to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service; **[and]**

(I) blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, subject to utilization controls deemed necessary by the Secretary for the efficient use of such factors;

(J) immunosuppressive drugs furnished to an individual who receives an organ transplant within 1 year after the date of the transplant procedure; and

(K)(i) services which are performed by a physician assistant (as defined in subsection (aa)(3)) under the supervision of a physician as defined in subsection (r)(1) in a hospital, skilled nursing facility, or as an assistant at surgery and which the physician assistant is legally authorized to perform by the State in which the services are performed, and

(ii) such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service;

* * * * *

(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition; [and]

(10)(A) pneumococcal vaccine and its administration; and

(B) hepatitis B vaccine and its administration, furnished to an individual who is at high or intermediate risk of contracting hepatitis B (as determined by the Secretary under regulation [.]); and

No diagnostic tests performed in any laboratory which is independent of a physician's office, a rural health clinic, or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1814(d)) shall be included within paragraph (3) unless such laboratory—

(11) services of a registered nurse anesthetist (as defined in subsection (bb)).

[(11)](12) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

[(12)](13) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2)(C) any item or service (except services referred to in paragraph (1)) which—

[(13)](14) would not be included under subsection (b) if it were furnished to an inpatient of a hospital; or

[(14)](15) is furnished under arrangements referred to in such paragraph (2)(C) unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff.

* * * * *

Reasonable Cost

(v)(1)(A) * * *

* * * * *

(L) The Secretary, in determining the amount of the payments that may be made under this title with respect to services furnished by home health agencies, may not recognize as reasonable (in the efficient delivery of such services) costs for the provision of such services by an agency to the extent these costs exceed (on the aggregate for the agency) the 75th percentile of such costs per visit for free standing home health agencies, or, in the judgment of the Secretary, such lower percentile or such comparable or lower limit (based on or related to the

mean of the costs of such agencies or otherwise) as the Secretary may determine. *Such limitations shall be applied on an aggregate basis for all home health services furnished by an agency, rather than on a discipline-specific basis, with appropriate adjustment for administrative and general costs of hospital-based agencies.* The Secretary may provide for such exemptions and exceptions to such limitation as he deems appropriate.

(5)(A) Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are furnished under an arrangement with a provider of services or other organization, specified in the first sentence of section 1861(p) (*including through the operation of section 1861(g)*) the amount included in any patient to such provider or other organization under this title as the reasonable cost of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement) plus the cost of such other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such therapy) incurred by such person, as the Secretary may in regulations determine to be appropriate.

* * * * *

Services of a Registered Nurse Anesthetist

(bb)(1) *The term "services of a registered nurse anesthetist" means anesthesia services and related care furnished by a registered nurse anesthetist (as defined in paragraph (2)) which the nurse anesthetist is legally authorized to perform as such by the State in which the services are furnished.*

(2) *The term "registered nurse anesthetist" means a registered nurse licensed by the State who meets such education, training, and other requirements relating to anesthesia services and related care as the Secretary may prescribe. In prescribing such requirements the Secretary may use the same requirements as those established by a national organization for the certification of nurse anesthetists.*

* * * * *

EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) which, except for items and services described in subparagraph (B), (C), or (D), are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,

(B) in the case of items and services described in section 1861(s)(10), which are not reasonable and necessary for the prevention of illness,

(C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness, [and]

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the Prospective Payment Assessment Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1886(e)(6) [;], and

(E) in the case of research conducted pursuant to section 1875(c), which is not reasonable and necessary to carry out the purposes of that section;

* * * * *

(14) which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph) and which are furnished to an individual who is an inpatient of a hospital by an entity other than the hospital, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the hospital or are services of a registered nurse anesthetist.

* * * * *

USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

SEC. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether an agency is a hospice program²⁹⁵ or whether a facility therein is a rural health clinic as defined in section 1861(aa)(2) or a comprehensive outpatient rehabilitation facility as defined in section 1861(cc)(2), or whether a laboratory meets the requirements of paragraphs [11] and [12] (12) and (13) of section 1861(s), or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861(p)(4), or whether an ambulatory surgical center meets the standards specified under section 1832(a)(2)(F)(i). To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, comprehensive outpatient rehabilitation facility, home health agency, or hospice program (as those terms are defined in section 1861) may be treated as such by the Secretary. Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility, after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory

to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1861(j). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization.

* * * * *

EFFECT OF ACCREDITATION

SEC. 1865. (a) Except as provided in subsection (b) and the second sentence of section 1863, if—

(1) an institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals, and

(2) such institution (if it is included within a survey described in section 1864(c)) authorizes the Commission to release to the Secretary upon his request (or such State agency as the Secretary may designate) a copy of the most current accreditation survey of such institution made by such Commission.

then, such institution shall be deemed to meet the requirements of the numbered paragraphs of section 1861(e); except—

(3) paragraph (6) thereof, and

(4) any standard, promulgated by the Secretary pursuant to paragraph (9) thereof, which is higher than the requirements prescribed for accreditation by such Commission.

If such Commission, as a condition for accreditation of a hospital, requires a utilization review plan (or imposes another requirement which serves substantially the same purpose) or imposes a standard which the Secretary determines is at least equivalent to the standard promulgated by the Secretary as described in paragraph (4) of this subsection, the Secretary is authorized to find that all institutions so accredited by such Commission comply also with section 1861(e)(6) or the standard described in such paragraph (4), as the case may be. In addition, if the Secretary finds that accreditation of an entity by the American Osteopathic Association or any other national accreditation body provides reasonable assurance that any or all of the conditions of section 1832(a)(2)(F)(i), 1861(e), 1861(f), 1861(j), 1861(o), 1861(p)(4)(A) or (B), paragraphs **[(11) and (12)]** (12) and (13) of section 1861(s), section 1861(aa)(2), 1861(cc)(2), or 1861(dd)(2), as the case may be, are met, he may, to the extent he deems it appropriate, treat such entity as meeting the condition or

conditions with respect to which he made such finding. The Secretary may not disclose any accreditation survey made and released to him by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association, or any other national accreditation body, of an entity accredited by such body.

* * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) * * *

* * * * *

(H) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1862(a)(14) *and other than services of a registered nurse anesthetist* (i) that are furnished to an individual who is an inpatient of the hospital, and (ii) for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital.

“(I) in the case of a hospital, to comply with the requirements of section 1867 to the extent applicable, [and]

“(J) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of title 10, or under section 613 of title 38, United States Code, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of title 10, United States Code[.],

["(I) (K) not to charge any individual or any other person for items or services for which payment under this title is denied under section 1154(a)(2) by reason of a determination under section 1154(a)(1)(B)[.], and

(L) in the case of hospitals—

(i) to make available to its patients the directory or directories of participating physicians (published under section 1842(h)(4)) for the area served by the hospital, and

(ii) if hospital personnel (including personnel of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis, the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one participat-

ing physician who is listed in such a directory and from whom the patient may receive the necessary services.

* * * * *

(e) For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) *(or meets the requirements of such section through the operation of section 1861(g))*, or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) *(or meets the requirements of such section through the operation of section 1861(g))*, but only with respect to the furnishing of outpatient physical therapy services (as therein defined) *or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services.*

* * * * *

DETERMINATIONS; APPEALS

SEC. 1869. (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A *or part B*, shall be made by the Secretary in accordance with regulations prescribed by him.

(b)(1) Any individual dissatisfied with any determination under subsection (a) as to—

(A) whether he meets the conditions of section 226 of this Act or section 103 of the Social Security Amendments of 1965, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this title or section 1818, or

(C) the amount of benefits under part A *or part B* (including a determination where such amount is determined to be zero) shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

[(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than \$100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than \$1,000.]

(2) *Notwithstanding paragraph (1)(C), in the case of a claim arising—*

(A) under part A, a hearing shall not be available to an individual under paragraph (1)(C) if the amount in controversy is less than \$100 and judicial review shall not be available to the individual under that paragraph if the amount in controversy is less than \$1,000; or

(B) under part B, a hearing shall not be available to an individual under paragraph (1)(C) if the amount in controversy is less than \$500 and judicial review shall not be available to the

individual under that paragraph if the aggregate amount in controversy is less than \$1,000.

In determining the amount in controversy, the Secretary, under regulations, shall allow two or more claims to be aggregated if the claims involve the delivery of similar or related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals.

(3) Paragraph (1) shall not be construed as authorizing any administrative law judge to review any national coverage determination under section 1862(a)(1) respecting whether or not a particular type or class of items or services is covered under this title.

* * * * *

STUDIES AND RECOMMENDATIONS

SEC. 1875. (a) The Secretary shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to health care of the aged and the disabled, including studies and recommendations concerning (1) the adequacy of existing personnel and facilities for health care for purposes of the programs under parts A and B; (2) methods for encouraging the further development of efficient and economical forms of health care which are a constructive alternative to inpatient hospital care; and (3) the effects of the deductibles and coinsurance provisions upon beneficiaries, persons who provide health services, and the financing of the program.

(b) The Secretary shall make a continuing study of the operation and administration of the insurance programs under parts A and B (including a validation of the accreditation process of the Joint Commission on Accreditation of Hospitals, the operation and administration of health maintenance organizations authorized by section 226 of the Social Security Amendments of 1972 the experiments and demonstration projects authorized by section 402 of the Social Security Amendments of 1967 and the experiments and demonstration projects authorized by section 222(a) of the Social Security Amendments of 1972), and shall transmit to the Congress annually a report concerning the operation of such programs.

(c)(1) *The Secretary shall establish a program (hereinafter in this subsection referred to as the 'research program') to provide for research with respect to patient outcomes of selected medical treatments and surgical procedures for the purpose of assessing their appropriateness, necessity, and effectiveness. The research program shall include—*

(A) assessments of the extent of uncertainty regarding appropriateness;

(B) assessments of the appropriateness of admissions or selection criteria;

(C) development of improved measures of patient outcome,

(D) evaluation of patient outcomes, and

(E) efforts to reduce existing levels of uncertainty or disagreement regarding appropriateness.

(2) *In selecting treatments and procedures to be studied, the Secretary shall give priority to those medical and surgical treatments and procedures—*

(A) for which data indicate a highly (or potentially highly) variable pattern of utilization among beneficiaries under this title in different geographic areas, and

(B) which are significant (or potentially significant) for purposes of this title in terms of utilization by beneficiaries, length of hospitalization associated with the treatment or procedure, costs to the program, and risk involved to the beneficiary.

(3) For purposes of carrying out the research program, there shall be available—

(A) from the Federal Hospital Insurance Trust Fund \$4,000,000 for fiscal year 1987 and \$5,000,000 for each of fiscal years 1988 and 1989, and

(B) from the Federal Supplementary Medical Insurance Trust Fund \$2,000,000 for fiscal years 1987 and \$2,500,000 for each of fiscal years 1988 and 1989.

(4) Not less than 90 percent of the amount appropriated for any fiscal year to carry out the research program shall be used to fund grants to, and cooperative agreements with, non-Federal entities to conduct research described in paragraph (1). The remainder may be used by the Secretary to provide such research by Federal entities and for administrative costs.

(5) The research program shall be administered by the National Center for Health Services Research and Health Care Technology established under section 305 of the Public Health Service Act (hereinafter in this subsection referred to as the "Center"). The Center shall establish application procedures for grants and cooperative agreements, and shall establish peer review panels to review all such applications and all research findings. The Center shall consult with the council on health care technology (established under a grant under section 309 of the Public Health Service Act) in establishing the scope and priorities for the research program and shall report periodically to any such council on the status of the program.

(6) The Secretary shall make available data derived from the programs under this title and other programs administered by the Secretary for use in the research program.

(7) The Center shall report to the Committees on Finance and Appropriations of the Senate and the Committees on Ways and Means, Energy and Commerce, and Appropriations of the House of Representatives not later than 18 months after the date of enactment of this Act, and annually thereafter, with respect to the findings under the research program. In cooperation with appropriate medical specialty groups, the Center shall disseminate such findings as widely as possible, including disseminating such findings to each peer review organization which has a contract under part B of title XI.

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a)(1)(A) The Secretary shall annually determine, and shall **[publish]** announce (in a manner intended to provide notice to interested parties) not later than September 7 before the calendar year concerned—

(i) a per capita rate of payment for each class of individuals who are enrolled under this section with an eligible organiza-

tion which has entered into a risk-sharing contract and who are entitled to benefits under part A and enrolled under part B, and

(ii) a per capita rate of payment for each class of individuals who are so enrolled with such an organization and who are enrolled under part B only.

For purposes of this section, the term "risk-sharing contract" means a contract entered into under subsection (g) and the term "reasonable cost reimbursement contract" means a contract entered into under subsection (h).

* * * * *

(f)(1) Each eligible organization with which the Secretary enters into a contract under this section shall have, for the duration of such contract, an enrolled membership at least one-half of which consists of individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.

(2) The Secretary may modify or waive the requirement imposed by paragraph (1) only [if the Secretary determines that—

(A) special circumstances warrant such modification or waiver, and

(B) the eligible organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.] *to the extent that more than 50 percent of the population of the area served by the organization consists of individuals who are entitled to benefits under this title or under a State plan approved under title XIX.*

(3) *If the Secretary determines that an eligible organization has failed to comply with the requirements of this subsection, the Secretary may provide for the suspension of payments to the organization under this section for individuals enrolled with the organization after the date the Secretary notifies the organization of such non-compliance.*

* * * * *

PENALTIES

SEC. 1877. (a) Whoever—

* * * * *

(b) * * *

* * * * *

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; [and]

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services[.]; and

(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are reimbursed under this title if—

(i) the person has a written contract with each such vendor and each such individual or entity which specifies the amount to be paid the person, which amount may be fixed amount or a fixed percentage (not to exceed 3 percent) of the value of the purchases made by each such individual or entity under the contract, and

(ii) the person discloses to each such individual or entity the amount received from each such vendor with respect to purchases made by or on behalf of the individual or entity.

* * * * *

LIMITATION ON LIABILITY OF BENEFICIARY WHERE MEDICARE CLAIMS ARE DISALLOWED

SEC. 1879. (a) Where—

* * * * *

(d) In any case arising under subsection (b) (but without regard to whether payments have been made by the individual to the provider or other person) or subsection (c), the provider or other person shall have the same right that an individual has under [section 1869(b) (when the determination is under part A) or section 1842(b)(3)(C) (when the determination is under part B)] *section 1869(b) and 1842(b)(3)(C) (as may be applicable)* when the amount of benefit or payments is in controversy, except that such rights may, under prescribed regulations, be exercised by such provider or other person only after the Secretary determines that the individual will not exercise such rights under such sections.

* * * * *

MEDICARE COVERAGE FOR END STAGE RENAL DISEASE PATIENTS

SEC. 1881. (a) The benefit provided by parts A and B of this title shall include benefits for individuals who have been determined to have end stage renal disease as provided in section 226A, and benefits for kidney donors as provided in subsection (d) of this section. Notwithstanding any other provision of this title, the type, duration, and scope of the benefit provided by parts A and B with respect to individuals who have been determined to have end stage renal disease and who are entitled to such benefits without regard to section 226A shall in no case be less than the type, duration, and scope of the benefits so provided for individuals entitled to such benefits solely by reason of that section.

(b)(1) * * *

* * * * *

(7) The Secretary shall provide by regulation for a method (or methods) for determining prospectively the amounts of payments to be made for dialysis services furnished by providers of service and renal dialysis facilities to individuals in a facility and to such individuals at home. Such method (or methods) shall provide for the

prospective determination of a rate (or rates) for each mode of care based on a single composite weighted formula (which takes into account the mix of patients who receive dialysis services at a facility or at home and the relative costs of providing such services in such settings) for hospital-based facilities and such a single composite weighted formula for other renal dialysis facilities, or based on such other method or combination of methods which differentiate between hospital-based facilities and other renal dialysis facilities and which the Secretary determines, after detailed analysis, will more effectively encourage the more efficient delivery of dialysis services and will provide greater incentives for increased use of home dialysis then through the single composite weighted formulas. *Each application for such an exception shall be deemed to be approved unless the Secretary disapproves it by not later than 45 working days after the date the application is filed.* The Secretary shall provide for such exceptions to such methods as may be warranted by unusual circumstances (including the special circumstances of sole facilities located in isolated, rural area and of pediatric facilities). The Secretary may provide that such method will serve in lieu of any target reimbursement rate that would otherwise be established under paragraph (6). *The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents and provide for payment of such amount to the network administrative organization (designated under subsection (c)(1)(A) for the network area in which the treatment is provided) for its necessary and proper administrative costs incurred in carry out its responsibilities under subsection (c)(2).*

* * * * *

[(c)(1)(A) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall establish, in accordance with such criteria as he finds appropriate, renal disease network areas, such network organization (including a coordinating council, and executive committee of such council, and a medical review board, for each network area) as he finds necessary to accomplish such purpose, and a national end stage renal disease medical information system. The Secretary may by regulations provide for such coordination of network planning and quality assurance activities and such exchange of data and information among agencies with responsibilities for health planning and quality assurance activities under Federal law as is consistent with the economical and efficient administration of this section and with the responsibilities established for network organizations under this section.]

(c)(1)(A)(i) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall, in accordance with such criteria as he finds necessary to assure the performance of the responsibilities and functions specified in paragraph (2)—

(I) establish at least 17 end stage renal disease network areas, and

(II) for each such area, designate a network administrative organization which, in accordance with regulations of the Sec-

retary, shall establish a network council of renal dialysis and transplant facilities located in the area, and a medical review board, which has a membership including physicians, nurses, and social workers engaged in treatment relating to end stage renal disease.

The Secretary shall publish in the Federal Register a description of the geographic area that he determines, after consultation with appropriate professional and patient organizations, constitutes each network area and the criteria on the basis of which such determination is made.

(ii)(I) In order to determine whether the Secretary should enter into, continue, or terminate an agreement with a network administrative organization designated for an area established under clause (i), the Secretary shall develop and publish in the Federal Register standards, criteria, and procedures to evaluate an applicant organization's capabilities to perform (and, in the case of an organization with which such an agreement is in effect, actual performance of) the responsibilities described in paragraph (2).

(II) An agreement with a network administrative organization may be terminated by the Secretary only if he finds, after applying such standards and criteria, that the organization has failed to perform its prescribed responsibilities effectively and efficiently. If such an agreement is to be terminated, the Secretary shall solicit applicants for such an agreement in accordance with provisions of law relating to competitive bidding so as to provide an orderly transition.

[(B) At least one patient representative shall serve as a member of each coordinating council and executive committee.]

(B) At least one patient representative shall serve as a member of each network council and each medical review board.

* * * * *

(2) the network organizations of each network shall be responsible, in addition to such other duties and functions as may be prescribed by the Secretary, for—

(A) encouraging, consistent with sound medical practice, the use of those treatment settings most compatible with the successful rehabilitation of the patient and the participation of patients, providers of services, and renal disease facilities in vocational rehabilitation programs;

(B) developing criteria and standards relating to the quality and appropriateness of patient care; and network goals with respect to the placement of patients in self-care settings and undergoing or preparing for transplantation and with respect to working with patients, facilities, and providers in encouraging participation in vocational rehabilitation programs;

(C) evaluating the procedure by which facilities and providers in the network assess the appropriateness of patients for proposed treatment modalities;

(D) implementing a procedure for evaluating and resolving patient grievances;

(E) conducting on-site reviews of facilities and providers as necessary (as determined by a medical review board), utilizing

standards of care established by the network organization to assure proper medical care;

(F) collecting, validating, and analyzing such data as are necessary to prepare the reports required by subparagraph (H) and subsection (g) and to assure the maintenance of the registry established under paragraph (7);

[(D)](G) identifying facilities and providers that are not cooperating toward meeting network goals and assisting such facilities and providers in developing appropriate plans for correction and reporting to the Secretary on facilities and providers that are not providing appropriate medical care; and

[(E)] (H) submitting an annual report to the Secretary on July 1 of each year which shall include a full statement of the network's goals, data on the network's performance in meeting its goals (including data on the comparative performance of facilities and providers with respect to the identification and placement of suitable candidates in self-care settings and transplantation and encouraging participation in vocational rehabilitation programs), identification of those facilities that have consistently failed to cooperate with network goals, and recommendations with respect to the need for additional or alternative services or facilities in the network in order to meet the network goals, including self dialysis training, transplantation, and organ procurement facilities.

(3) Where the Secretary determines, on the basis of the data contained in the network's annual report and such other relevant data as may be available to him, that a facility or provider has consistently failed to cooperate with network plans and goals *or to follow the recommendations of the medical review board* he may terminate or withhold certification of such facility or provider (for purposes of payment for services furnished to individuals with end stage renal disease) until he determines that such provider or facility is making reasonable and appropriate efforts to cooperate with network's plans and goals. If the Secretary determines that the facility's or provider's failure to cooperate with network plans and goals does not jeopardize patient health or safety or justify termination of certification, he may instead, after reasonable notice to the provider or facility and to the public, impose such other sanctions as he determines to be appropriate, which sanctions may include denial of reimbursement with respect to some or all patients admitted to the facility after the date of notice to the facility or provider, and graduated reduction in reimbursement for all patients.

* * * * *

(6) It is the intent of the Congress that the maximum practical number of patients who are medically, socially, and psychologically suitable candidates for home dialysis or transplantation should be so treated *and that the maximum practical number of patients who are suitable candidates for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment.* The Secretary shall consult with appropriate professional and network organizations and consider available evidence relating to developments in research, treatment methods, and technology for home dialysis and transplantation. The Secretary shall

periodically submit to the Congress such legislative recommendations as the Secretary finds warranted on the basis of such consultation and evidence to further the national objective of maximizing the use of home dialysis and transplantation consistent with good medical practice.

(7) *The Secretary shall establish a national end stage renal disease registry the purpose of which shall be to assemble and analyze the data reported by network organizations, transplant centers, and other sources on all end stage renal disease patients in a manner that will permit—*

(A) *the preparation of the annual report to the Congress required under subsection (g);*

(B) *an identification of the economic impact, cost-effectiveness, and medical efficacy of alternative modalities of treatment;*

(C) *an evaluation with respect to the most appropriate allocation of resources for the treatment and research into the cause of end stage renal disease;*

(D) *the determination of patient mortality and morbidity rates, and trends in such rates, and other indices of quality of care; and*

(E) *such other analyses relating to the treatment and management of end stage renal disease as will assist the Congress in evaluating the end stage renal disease program under this section.*

The Secretary shall provide for such coordination of data collection activities, and such consolidation of existing end stage renal disease data systems, as is necessary to achieve the purpose of such registry, shall determine the appropriate location of the registry, and shall provide for the appointment of a professional advisory group to assist the Secretary in the formulation of policies and procedures relevant to the management of such registry.

* * * * *

(f)(1) * * *

* * * * *

[(7) *The Secretary shall conduct a study of the medical appropriateness and safety of cleaning and reusing dialysis filters by home dialysis patients. In such cases in which the Secretary determines that such home cleaning and reuse of filters is a medically sound procedure, the Secretary shall conduct experiments to evaluate such home cleaning and reuse as a method of reducing the costs of the end stage renal disease program.*]

(7)(A) *The Secretary shall establish protocols on standards and conditions for the reuse of dialyzer filters for those facilities and providers which voluntarily elect to reuse such filters.*

(B) *The Secretary shall study and review the appropriateness of establishing protocols on standards and conditions for the reuse (where appropriate) of other dialysis supplies (such as blood lines, transducer filters, and dialyzer caps). If the Secretary determines that the establishment of such a protocol with respect to such a dialysis supply is appropriate, the Secretary may establish such a protocol.*

(C) If a renal disease facility fails to follow a protocol established under this paragraph in the reuse of a dialyzer filter or other dialysis supply, the facility shall be subject to such a penalty as the Secretary may establish.

* * * * *

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a)(1)(A)(i) * * *

* * * * *

(4) For purposes of this section, the term "operating costs of inpatient hospital services" includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services as such costs are determined on an average per admission or per discharge basis (as determined by the Secretary). Such term does not include costs of approved educational activities, [costs of anesthesia services provided by a certified registered nurse anesthetist,] *a return on equity capital*; or, with respect to costs incurred in cost reporting periods beginning prior to October 1, 1986, other capital-related costs, as defined by the Secretary.

* * * * *

(d)(1)(A) * * *

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(5)(A)(i) * * *

* * * * *

[(E) The Secretary shall provide for an additional payment amount for any subsection (d) hospital equal to the reasonable costs incurred by such hospital for anesthesia services provided by a certified registered nurse anesthetist. Payment under this subparagraph shall be the only payment made to such hospital with respect to such services.]

* * * * *

(h) PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—

(1) * * *

* * * * *

(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

(A) RULES.—The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.

(B) ADJUSTMENT FOR PART-YEAR OR PART-TIME RESIDENTS.—Such rules shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital.

(C) WEIGHTING FACTORS FOR CERTAIN RESIDENTS.—Subject to subparagraph (E), such rules shall provide, in calculat-

ing the number of full-time-equivalent residents in an approved residency program—

(i) before July 1, 1986, for each resident the weighting factor is 1.00,

(ii) on or after July 1, 1986, for a resident who is in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is 1.00,

(iii) on or after July 1, 1986, and before July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .75, and

(iv) on or after July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .50.

(D) *COUNTING TIME SPENT IN OUTPATIENT SETTINGS.*—*Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs costs for the training program in that setting.*

(E) FOREIGN MEDICAL GRADUATES REQUIRED TO PASS FMGEMS EXAMINATION.—

(i) * * *

* * * * *

(ii) *TRANSITION FOR CURRENT FMGS.*—On or after July 1, 1986, but before July 1, 1987, in the case of a foreign medical graduate who—

(I) has served as a resident before July 1, 1986, and is serving as a resident after that date, but

(II) has not passed the FMGEMS examination or a previous examination of the Educational Commission for Foreign Medical Graduates before July 1, 1986,

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

(5) *DEFINITIONS AND SPECIAL RULES.*—As used in this subsection:

(A) * * *

* * * * *

(F) *INITIAL RESIDENCY PERIOD.*—The term “initial residency period” means the period of board eligibility plus one year, except that—

(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of formal training of more than [five] four years for any individual, and

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * *

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1864(a)), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1861(e)(9) or paragraphs [(11) and (12)] (12) and (13) of section 1861(s), or, in the case of a laboratory which is in a rural health clinic, of section 1861(aa)(2)(G);

* * * * *

PENALTIES

SEC. 1909. (a) Whoever—

* * * * *

(b)(1) * * *

* * * * *

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; [and]

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or service[.]; and

(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are reimbursed under this title if—

(i) the person has a written contract with each such vendor and each such individual or entity which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage (not to exceed 3 percent)

of the value of the purchases made by each such individual or entity under the contract, and

(ii) the person discloses to each such individual or entity the amount received from each such vendor with respect to purchases made by or on behalf of the individual or entity.

* * * * *

PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN REQUIREMENTS OF THIS TITLE

SEC. 1915. (a) A State shall not be deemed to be out of compliance with the requirements of paragraphs (1), (10), or (23) of section 1902(a) solely by reason of the fact that the State (or any political subdivision thereof)—

(1) has entered into—

(A) a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic; or

(B) arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1905(a)(3) or medical devices if the Secretary has found that—

(i) adequate services or devices will be available under such arrangements, and

(ii) any such laboratory services will be provided only through laboratories—

(I) which meet the applicable requirements of section 1861(e)(9) or paragraphs [(11) and (12)] (12) and (13) of section 1861(s), and such additional requirements as the Secretary may require, and

(II) no more than 75 percent of whose charges for such services are for services provided to individuals who are entitled to benefits under this title or under part A or part B of title XVIII; or

* * * * *

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

* * * * *

TITLE IX—MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS

* * * * *

Subtitle A—Medicare

PART 1—PROVISIONS RELATING TO PART A OF MEDICARE

* * * * *

Subpart B—Miscellaneous Provisions

* * * * *

SEC. 9127. ADDITIONAL MEMBERS OF PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.

(a) **EXPANSION OF MEMBERSHIP.**—Section 1886(e)(6)(A) of the Social Security Act (42 U.S.C. 1395ww(e)(6)(A)) is amended by striking out “15 individuals” and inserting in lieu thereof “17 individuals”.

(b) **APPOINTMENTS.**—The Director of the Congressional Office of Technology Assessment shall appoint the two additional members of the Prospective Payment Assessment Commission, as required by the amendment made by subsection (a), no later than 60 days after the date of the enactment of this Act, for terms of three years, *except that the Director may provide initially for such terms as will insure that (on a continuing basis) the terms of no more than eight members will expire in any one year.*

* * * * *

PART 2—PROVISIONS RELATING TO PARTS A AND B OF MEDICARE

Subpart A—Payment-Related Provisions

* * * * *

SEC. 9202. PAYMENTS TO HOSPITALS FOR DIRECT COSTS OF MEDICAL EDUCATION.

(a) * * *

* * * * *

(j) **SPECIAL TREATMENT OF STATES FORMERLY UNDER WAIVER.**—In the case of a hospital in a State that has had a waiver approved under section 1886(c) of the Social Security Act *or section 402 of the Social Security Amendments of 1967* for cost reporting periods beginning on or after January 1, 1986, if the waiver is terminated—

(1) the Secretary of Health and Human Services shall permit the hospital to change the method by which it allocates administrative and general costs to the direct medical education cost centers to the method specified in the medicare cost report;

(2) the Secretary may make appropriate adjustments in the regional adjustment DRG prospective payment rate (for the region in which the State is located), based on the assumption that all teaching hospitals in the State use the medicare cost report; and

(3) the Secretary shall adjust the hospital-specific portion of payment under section 1886(d) of such Act for any such hospital that actually chooses to use the medicare cost report.

The Secretary shall implement this subsection based on the best available data.

* * * * *

Subpart B—Other Provisions

* * * * *

SEC. 9221. CONTINUATION OF “ACCESS: MEDICARE” DEMONSTRATION PROJECT.

(a) **APPROVAL OF APPLICATION.**—The Secretary of Health and Human Services shall approve any application for a waiver of any requirement of titles XVIII and XIX of the Social Security Act necessary to provide for the continuation, through [September 30, 1986] *July 31, 1987*, of the “Access: Medicare” demonstration project carried out pursuant to section 222 of the Social Security Amendments of 1972 and section 402(a) of the Social Security Amendments of 1967 by Monroe County Long Term Care Program, Inc.

(b) **TERMS AND CONDITIONS.**—The Secretary’s approval of an application (or renewal of an application) under subsection (a) shall be on the same terms and conditions as applied to the demonstration project as in effect on August 31, 1985.

PART 3—PROVISIONS RELATING TO PART B OF MEDICARE

Subpart A—Payment-Related Provisions

SEC. 9301. MEDICARE PHYSICIAN PAYMENT PROVISIONS.

(a) * * *

* * * * *

(c) **INCENTIVES FOR PARTICIPATING PHYSICIAN PROGRAM—**

(1) * * *

* * * * *

(5) **EFFECTIVE DATE.**—Section [1842(b)(7)] *1842(h)(7)* of the Social Security Act, as added by paragraph (4) of this subsection, shall apply to explanations of benefits provided on or after such date (not later than October 1, 1986) as the Secretary of Health and Human Services shall specify.

* * * * *

TITLE V—MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT

AUTHORIZATION OF APPROPRIATIONS

SEC. 501. (a) For the purpose of enabling each State—

(1) * * *

* * * * *

and for the purpose of enabling the Secretary to provide for special projects of regional and national significance, research, and training with respect to maternal and child health and children with

special health care needs, for genetic disease testing, counseling, and information development and dissemination programs, and for grants relating to hemophilia (without regard to age), there are authorized to be appropriated **[\$478,000,000 for fiscal year 1984]** *\$553,000,000 for fiscal year 1987, \$557,000,000 for fiscal year 1988, and \$561,000,000 for fiscal year 1989 and each fiscal year thereafter.*

* * * * *

ALLOTMENTS TO STATES AND FEDERAL SET-ASIDE

SEC. 502. (a)(1)(A) Of the amount appropriated under section 501(a), the Secretary shall retain an amount equal to 15 percent thereof in the case of fiscal year 1982, and an amount equal to not less than 10, nor more than 15, percent thereof in the case of each fiscal year thereafter, for the purpose of carrying out (through grants, contracts, or otherwise) special projects of regional and national significance, training, and research and for the funding of genetic disease testing, counseling, and information development and dissemination programs and of comprehensive hemophilia diagnostic and treatment centers. The authority of the Secretary to enter into any contracts under this title is effective for any fiscal year only to such extent or in such amounts as are provided in appropriations Acts.

(B) Of the amount appropriated under section 501(a), the Secretary shall also retain \$7,000,000 in fiscal year 1987, \$7,500,000 in fiscal year 1988, and \$8,000,000 in fiscal year 1989 for the purpose of carrying out (through grants, contracts, or otherwise) projects for the screening of newborns for sickle-cell anemia and other genetic disorders.

* * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * *

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a), to—

(i) all individuals—

(I) * * *

(II) with respect to whom supplemental security income benefits are being paid under title XVI
or who are qualified severely impaired individuals (as defined in section 1905(2)), or

* * * * *

(ii) at the option of the State, to any group or groups of individuals described in section 1905(a) (or, in the case of individuals described in section 1905(a)(i), to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) * * *

(VII) who would be eligible under the State plan under this title if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1905(o) **[, or]**;

(VII) who is a child described in section 1905(a)(i)—

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of title IV) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of title IV were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of title IV;

(IX) subject to subsection (l)(4), who are described in subsection (l)(1), or

(X) subject to subsection (m)(3), who are described in subsection (m)(1);

* * * * *

(C) that if medical assistance is included for any group of individuals described in section 1905(a) who were not described in subparagraph (A) or (E), then—

(i) * * *

* * * * *

(iv) if such medical assistance includes services in institutions for mental diseases or intermediate care facility services for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) or the care and services listed in any 7 of the paragraphs numbered (1) through **[(18)] (19)** of such section; **[and]**

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services; and

(E) at the option of a State but subject to subsection (m)(3), for making medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3)) for qualified medicare beneficiaries described in section 1905(p)(1);

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1916(a)(2) or (b)(2) shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, [and] (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1905(o) to receive hospice care instead of medical assistance for certain other services, such assistance

may not be made available in an amount, duration, or scope less than that provided under title XVIII, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, *(VII) the medical assistance made available to an individual described in subsection (1)(1)(A) who is eligible for medical assistance only because of subparagraph (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, and postpartum services) and to other conditions which may complicate pregnancy, and (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1905(p)(1) shall be limited to medical assistance for medicare cost-sharing (described in section 1905(p)(3)), subject to the provisions of subsection (n) and section 1916(b);*

(13) provide—

(A) * * *

* * * * *

(D) for payment for hospice care in the same amounts, and using the same methodology, as used under part A of title XVIII; except that a separate rate may be paid for hospice care which is furnished to an individual who is a resident of a skilled nursing facility or intermediate care facility, and who would be eligible under the plan for skilled nursing facility services or intermediate care facility services if he had not elected to receive hospice care, to take into account the room and board furnished by such facility; and

* * * * *

(15) in the case of eligible individuals 65 years of age or older who are not qualified medicare beneficiaries (as defined in section 1905(p)(1)) but are covered by either or both of the insurance programs established by title XVIII, provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by such title is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources;

* * * * *

(17) except as provided in subsection (1)(3), include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, based on the variations be-

tween shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or to have paid with respect to him supplemental security income benefits under title XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual or any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

* * * *

(30)(A) * * *

* * * *

(C) provide a utilization and quality control peer review organization (under part B of title XI) or a private accreditation body to conduct (on an annual basis) an independent, external review of the quality of services furnished under each contract under section 1903(m), with the results of such review made available to the State and, upon request, to the Secretary, the Inspector General in the Department of Health and Human Services, and the Comptroller General;

* * * *

The requirement of clause" (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has excused good faith in trying to meet such requirement. For purposes of this title, any child who meets the requirements of paragraph (1) or (2) of section 473(b) shall be deemed to be a dependent child as defined in section 406 and shall be deemed to be a recipient of aid to families with dependent children under part A of title IV in the State where such child resides. *Notwithstanding paragraph (10) or any other provision of this subsection, nothing in this title shall be construed as requiring a State plan to provide medical assistance with respect to an alien who is not lawfully ad-*

mitted for permanent residence or otherwise permanently residing in the United States under color of law.

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan—

- (1) an age requirement of more than 65 years; or
- (2) any residence requirement which excludes any individual who resides in the State, *regardless of whether or not the residence is maintained permanently or at a fixed address; or*

* * * * *

(d) If a State contracts with a utilization and quality control peer review organization having a contract with the Secretary under part B of title XI for the performance of medical or utilization review functions (*including quality review functions described in subsection (a)(30)(C)*) required under this title of a State plan with respect to specific services or providers (or services or providers in a geographic area of the State), such requirements shall be deemed to be met for those services or providers (or services or providers in that area) by delegation to such organization (or organizations) under the contract of the State's authority to conduct such review activities if the contract provides for the performance of activities not inconsistent with part B of title XI and provides for such assurances of satisfactory performance by such organization (or organizations) as the Secretary may prescribe.

(e)(1) * * *

* * * * *

(6) *At the option of a State, if a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX), the plan may provide that any woman described in such subsection and subsection (1)(1)(A) shall continue to be treated as an individual described in subsection (a)(10)(A)(ii)(IX) without regard to any change in income of the family of which she is a member until the end of the 60-day period beginning on the last date of her pregnancy.*

(7) *If a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX), in the case of an infant described in subsection (1)(1)(B)—*

(A) who is receiving inpatient services for which medical assistance is provided on the date the infant becomes one year of age, and

(B) who, but for becoming one year of age, would remain eligible for medical assistance as under such subsection, the infant shall continue to be treated as an individual described in subsections (a)(10)(A)(ii)(IX) and (1)(1)(B) until the end of the stay for which the inpatient services are furnished.

(8) *If an individual is determined to be a qualified medicare beneficiary (as defined in section 1905(p)(1)), such determination shall apply to services furnished after the end of the month in which the determination first occurs. For purposes of payment to a State under section 1903(a), such determination shall be considered to be valid for an individual for a period of 12 months, except that a State may*

provide for such determinations more frequently, but not more frequently than once every 6 months for an individual.

(h)(1) Nothing in this title (including subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payment that may be made under a plan under this title with respect to inpatient hospital services, skilled nursing facility services, or intermediate care facility services, including any such limitation relating to the amount that can reasonably be estimated would have been paid for such services under the reimbursement principles applicable under title XVIII.

(2) Nothing in this title (including subsections (a)(4) and (a)(30) of this section) shall be construed as authorizing the Secretary to require that States operate second surgical opinion programs or inpatient hospital preadmission review programs.

* * * * *

(j) Notwithstanding any other requirement of this title, the Secretary may waive or modify any requirement of this title with respect to the medical assistance program in American Samoa, other than a waiver of the Federal medical assistance percentage, the limitation in section 1108(c), or the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa for care and services described in paragraphs (1) through [(19)] (20) of section 1905(a).

* * * * *

(l)(1) An individual described in this paragraph is—

(A) a woman during pregnancy (and during the 60-day period beginning on the last date of her pregnancy), and

(B) an infant under one year of age or, in the case described in subsection (e)(7), older,

who is not described in subsection (a)(10)(A)(i) and whose family income does not exceed the maximum income level established by the State under paragraph (2) for a family size equal to the size of the family including the woman or infant. A State may not elect, under subsection (a)(10)(A)(ii)(IX), to cover only individuals described in subparagraph (A) or to cover only individuals described in subparagraph (B).

(2)(A) For purposes of paragraph (1) and subject to subparagraph (B), the State shall establish a maximum income level which is a percentage (not more than 100 percent) of the nonfarm income official poverty line defined by the Office of Management and Budget (and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(B) The maximum income level established under subparagraph (A) for a family may not be less than the payment level applicable to a family of that size and with no income under the State plan approved under part A of title IV.

(3) Notwithstanding subsection (a)(17), for individuals who are eligible for medical assistance because of subsection (a)(10)(A)(ii)(IX) or coverage under subsection (a)(10)(E)—

(A)(i) no resource standard or methodology may be applied with respect to an individual described in paragraph (1)(A),

(ii) any resource standard or methodology which is applied with respect to an individual described in paragraph (1)(B) may not be more restrictive than the corresponding resource standard or methodology which is applied under the State plan under part A of title IV,

(B) the income standard to be applied is the income standard established under paragraph (2), and

(C) family income shall be determined in accordance with the methodology employed under the State plan under part A of title IV (without regard to section 402(a)(18)), and costs incurred for medical care or for any other type of remedial care shall not be taken into account.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(4) A State plan may not elect the option of furnishing medical assistance to individuals described in subsection (a)(10)(A)(ii)(IX) unless the State has in effect, under its plan established under part A of title IV, payment levels that are not less than the payment levels in effect under its plan on April 17, 1986.

(5) Notwithstanding subsection (a)(17), for qualified medicare beneficiaries described in section 1905(o)(1)—

(A) the income standard to be applied is the income standard described in section 1905(p)(1)(C), and

(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(m)(1) Individuals described in this paragraph are individuals—

(A) who are 65 years of age or older or are disabled individuals (as determined under section 1614(a)(3)),

(B) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed an income level established by the State consistent with paragraph (2)(A), and

(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed (except as provided in paragraph (2)(B)) the maximum amount of resources that an individual may have and obtain benefits under that program.

(2)(A) The income level established under paragraph (1)(B) may not exceed a percentage (not more than 100 percent) of the nonfarm official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(B) In the case of a State that provides medical assistance to individuals not described in section 1902(a)(10)(A) and at the State's option, the State may use under paragraph (1)(C) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in section 1902(a)(10)(A).

(3) A State plan may not provide coverage for individuals under subsection (a)(10)(A)(ii)(X), unless the plan provides coverage of some of the individuals described in subsection (1)(1).

(4) Notwithstanding subsection (a)(17), for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(X)—

(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(n) In the case of medical assistance furnished under this title for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under title XVIII with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

(o) In applying subsection (a)(17) and notwithstanding any provision in that subsection to the contrary, in determining the income and resources of an individual who is in an institution, the individual shall not be considered to have available to him or her income or resources which are required to be paid under court order for the support of the individual's spouse or child.

PAYMENT TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g), (h), and (j) of this section) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for deductible amounts under part A and premiums under part B (and, in the case of qualified medicare beneficiaries described in section 1905(p)(1), part A) of title XVIII, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) are qualified medicare beneficiaries described in section 1905(p)(1), or (C) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals sixty-five

years of age or older and disabled individuals entitled to hospital insurance benefits under title XVIII who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof; plus

* * * * *

(3) an amount equal to

(A) * * *

* * * * *

(C) 75 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of medical and utilization review *or quality review* by a utilization and quality control peer review organization under a contract entered into under section 1902(d); plus

* * * * *

(f)(1) * * *

* * * * *

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance *for any individual described in section 1902(a)(10)(A)(ii)(IX) or for any individual—*

(A) * * *

* * * * *

(i) Payment under the preceding provisions of this section shall not be made—

* * * * *

(7) with respect to any amount expended for clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital, to the extent such amount exceeds the amount that would be recognized under section 1833(h) for such tests performed for an individual enrolled under part B of title XVIII **[.]**; *or*

(8) for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or permanently residing in the United States under color of law.

* * * * *

(m)(1) * * *

(2)(A) Except as provided in subparagraphs (B), (C), and (G), no payment shall be made under this title to a State with respect to expenditures incurred by it for payment (determined under a pre-paid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization) which is responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1905(a) or for the provision of any three or more of the services described in such paragraphs unless—

(i) * * *

(iii) such services are provided for the benefit of individuals eligible for benefits under this title in accordance with a contract between the State and the entity under which prepaid payments to the entity are made on an actuarially sound basis *and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of \$100,000;*

* * * * *

(vi) such contract (I) except as provided under subparagraph (F), permits individuals who have elected under the plan to enroll with the entity for provision of such benefits to terminate such enrollment without cause as of the beginning of the first calendar month following a full calendar month after the request is made for such termination, and (II) provides for notification of each such individual, at the time of the individual's enrollment, of such right to terminate such enrollment; **[and]**

(vii) such contract provides that, in the case of medically necessary services which were provided (I) to an individual enrolled with the entity under the contract and entitled to benefits with respect to such services under the State's plan and (II) other than through the organization because the services were immediately required due to an unforeseen illness, injury, or condition, either the entity or the State provides for reimbursement with respect to these services**[.]**, and

(viii) *such contract provides for disclosure of information in accordance with section 1124 and paragraph (4) of this subsection.*

* * * * *

(F) **[in]** *In the case of a contract with an entity described in subparagraph (G) or with a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) which meets the requirement of subparagraph (A)(ii), a State plan may restrict the period in which requests for termination of enrollment without cause under subparagraph (A)(vi)(I) are permitted to the first month of each period of enrollment, each such period of enrollment not to exceed six months in duration, but only if the State provides notification, at least twice per year, to individuals enrolled with such entity or organization of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to requests for termination of enrollment for cause.*

* * * * *

(4)(A) *Each health maintenance organization which is not a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General a description of transactions between the organization and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:*

(i) *Any sale or exchange, or leasing of any property between the organization and such party.*

(ii) Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

(iii) Any lending of money or other extension of credit between the organization and such a party.

The State or Secretary may require that information reported respecting an organization which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(B) Each organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

* * * * *

(q) For the purposes of this section, the term "State medicaid fraud control unit" means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

(1) * * *

* * * * *

The Secretary shall provide (or continue to provide) for the delegation of the Secretary's authority under this subsection to the Inspector General in the Department of Health and Human Services.

* * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of a qualified medicare beneficiary described in section 1905(p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are—

(i) * * *

* * * * *

(viii) pregnant women,
but whose income and resources are insufficient to meet all of such cost—

(1) * * *

* * * * *

(18) hospice care (as defined in subsection (o)); **[and]**

(19) case-management services (as defined in section 1915(g)(2)); and

[(19)] (20) any other medical care, and any other type of remedial care recognized under state law, specified by the Secretary;

* * * * *

(p)(1) The term “qualified medicare beneficiary” means an individual—

(A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818),

(B) who, but for section 1902(a)(10)(E) and the election of the State, is not eligible for medical assistance under the plan,

(C) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed an income level established by the State consistent with paragraph (2)(A), and

(D) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed (except as provided in paragraph (2)(B)) the maximum amount of resources that an individual may have and obtain benefits under that program.

(2)(A) The income level established under paragraph (1)(C) may not exceed a percentage (not more than 100 percent) of the nonfarm official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(B) In the case of a State that provides medical assistance to individuals not described in section 1902(a)(10)(A) and at the State's option, the State may use under paragraph (1)(D) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in section 1902(a)(10)(A).

(3) The term “medicare cost-sharing” means that following costs incurred with respect to a qualified medicare beneficiary:

(A) Premiums under part B.

(B) Deductibles and coinsurance described in section 1813.

(C) The annual deductible described in section 1833(b).

(D) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to “80 percent” therein were deemed a reference to “100 percent”.

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1876.

(q) The term “qualified severely impaired individual” means an individual under age 65—

(1) who received (A) a payment of supplemental security income benefits under section 1611(b) on the basis of blindness or disability, (B) a supplementary payment under section 1616 of this Act or under section 212 of Public Law 93-66 on such basis, (C) a payment of monthly benefits under section 1619(a), or (D) a supplementary payment under section 1616(c)(3), and

(2) for so long as the Secretary determines that—

(A) the individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, continues to meet all non-disability-related requirements for eligibility for benefits under title XVI,

(B) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611(b) (if he were otherwise eligible for such payments),

(C) the lack of eligibility for benefits under this title would seriously inhibit his ability to continue or obtain employment, and

(D) the individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under title XVI and this title and attendant care paid for under title XX which would be available to him in the absence of such earnings.

PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN REQUIREMENTS OF THIS TITLE

SEC. 1915.(a) * * *

(c)(1) The Secretary may by waiver provide that a State plan approved under this title may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan or but for the provision of such services the individuals would continue to receive inpatient hospital services, skilled nursing facility services, or intermediate care facility services because they are dependent on ventilator support the cost of which is reimbursed under the State plan or because they have been diagnosed as having acquired immune deficiency syndrome (AIDS) or AIDS-related conditions the cost of treatment with respect to which is reimbursed under the State plan or because they have chronic mental illness the cost of treatment with respect to which is reimbursed under the State plan.

* * * * *

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness [and section 1902(a)(10)]. A waiver under this subsection shall be for an initial term of three years and, upon request of a State, shall

be extended for additional three-year periods unless the Secretary determines that for the previous three-year period the assurances provided under paragraph (2) have not been met,] and section 1902(a)(10)(B) (relating to comparability of medical assistance).

* * * * *

(4) A waiver granted under the subsection may, consistent with paragraph (2)—

* * * * *

(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve *and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness*

(5) For purposes of paragraph (4)(B), the term 'habilitation services', with respect to individuals who receive such services after discharge from a skilled nursing facility or intermediate care facility—

(A) means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings; and

(B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services; but

(C) does not include—

(i) special education related services (as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16), (17)) which otherwise are available to the individual through a local educational agency; and

(ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(6) The Secretary may not require, as a condition of approval of a waiver under this section under paragraph (2)(D), that the actual total expenditures for home and community-based services under the waiver (and a claim for Federal financial participation in expenditures for the services) cannot exceed the approved estimates for these services. The Secretary may not deny Federal financial payment with respect to services under such a waiver on the ground that, in order to comply with paragraph (2)(D), a State has failed to comply with such a requirement.

(7) (A) In making estimates under paragraph (2)(D) in the case of a waiver which applies only to physically disabled individuals who are inpatients in skilled nursing or intermediate care facilities, the State may determine the average per capita expenditure which would have been made in fiscal year for those individuals under

the State plan separately from the expenditure for other individuals who are inpatients of those facilities.

(B) In making estimates under paragraph (2)(D) in the case of a waiver which applies only to individuals with acquired immune deficiency syndrome (AIDS), or with AIDS-related conditions, or with either, who are inpatients in hospitals or in skilled nursing or intermediate care facilities, the State may determine the average per capita expenditure which would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients of those respective facilities.

(C) In making estimates under paragraph (2)(D) in the case of a waiver which applies only to individuals with chronic mental illness, who are inpatients in hospitals or in skilled nursing or intermediate care facilities, the State may determine the average per capita expenditure which would have been made in a fiscal year for those individuals under the State plan separately from the expenditure for other individuals who are inpatients of those respective facilities.

* * * * *

(d) No waiver under this section (other than a waiver under subsection (c)) may extend over a period of longer than two years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary denies such request in writing within 90 days after the date of its submission to the Secretary.

(e)(1) The Secretary shall monitor the implementation of waivers granted under this section to assure that the requirements for such waiver are being met and shall, after notice and opportunity for a hearing, terminate any such waiver where he finds noncompliance has occurred.

(2) The Secretary shall report, not later than September 30, 1984, to Congress on waivers granted under this section.

(f) A request to the Secretary from a State for approval of a proposed State plan or plan amendment or a waiver of a requirement of this title submitted by the State pursuant to a provision of this title shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

(g)(1) A State may provide, as medical assistance, case management services under the plan without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B). The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1902(a)(23).

(2) For purposes of this subsection, the term "case management services" means services which will assist individuals eligible

under the plan in gaining access to needed medical, social, educational, and other services.

A State may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS), or with AIDS-related conditions, or with either.

A State may limit the provision of case management services under this subsection to individuals with chronic mental illness.

USE OF ENROLLMENT FEES, PREMIUMS, DEDUCTIONS, COST SHARING,
AND SIMILAR CHARGES

SEC. 1916. [42 U.S.C. 1396o] (a) The State plan shall provide that in the case of individuals described in [section 1902(a)(10)(A)] subparagraph (A) or (E) of section 1902(a)(10) who are eligible under the plan—

(1) no enrollment fee, premium, or similar charge will be imposed under the plan;

(2) no deduction, cost sharing or similar charge will be imposed under the plan with respect to—

(A) * * *

* * * * *

(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1905(a)(4)(C), or services furnished to such an individual by a health maintenance organization (as defined in section 1903(m) in which he is enrolled, or;

(E) services furnished to an individual who is receiving hospice care (as defined in section 1905(o)); and

(b) The State plan shall provide that in the case of individuals other than those described in section [1902(a)(10)(A)] subparagraph (A) or (E) of section 1902(a)(10) who are eligible under the plan—

(1) there may be imposed an enrollment fee, premium, or similar charge, which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income,

(2) no deduction, cost sharing, or similar charge will be imposed under the plan with respect to—

(A) * * *

* * * * *

(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1905(a)(4)(C), or (at the option of the State) services furnished to such an individual by a health maintenance organization (as defined in section 1903(M)) in which he is enrolled, or;

(E) services furnished to an individual who is receiving hospice care (as defined in section 1905(o)); and

* * * * *

"CORRECTION AND REDUCTION PLANS FOR INTERMEDIATE CARE
FACILITIES FOR THE MENTALLY RETARDED

SEC. 1919. (a) * * *

(c) The reduction plan must—

(1) * * *

(6) provide that the ratio of qualified staff to residents at the affected facility (or the part thereof) which is subject to the reduction plan will be the higher of—

(A) the ratio which the Secretary determines is necessary in order to assure the health and safety of the residents of such facility (or part thereof); or

(B) the ratio which was in effect at the time that the finding of substantial deficiencies (referred to in subsection

(a) was made; [and]

(7) provide for the protection of the interests of employees affected by actions under the reduction plan, including—

(A) arrangements to preserve employee rights and benefits;

(B) training and retraining of such employees where necessary;

(C) redeployment of such employees to community settings under the reduction plan; and

(D) making maximum efforts to guarantee the employment of such employees (but this requirements shall not be construed to guarantee the employment of any employee; and

(8) assure that the existing facility continues to provide active treatment (described in section 1905(d)(2) to the remaining residents during the phaseout period.

(3) FOSTER CARE AND ADOPTION ASSISTANCE.—[Section 473(b)] Sections 472(h) and 473(b) of this Act (relating to medical assistance for children in foster care and for adopted children).

REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

SEC. 1920. (a) AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.—For provisions of law which make additional individuals eligible for medical assistance under this title, see the following:

(1) AFDC.—(A) Section 482(a)(32) of this Act (relating to individuals who are deemed recipients of aid but for whom a payment is not made).

(B) Section 402(a)(37) of this Act (relating to individuals who lose AFDC eligibility due to increased earnings).

[(B)] (C) Section 406(h) of this Act (relating to individuals who lose AFDC eligibility due to increased collection of child or spousal support).

[(C)] (D) Section 414(g) of this Act (relating to individuals participating in work supplementation programs).

(2) SSI.—(A) Section 1634(b) of this Act (relating to preservation of benefit status for disabled widows and widowers who lost SSI benefits because of 1983 changes in actuarial reduction formula).

(B) Section 1619 of this Act (relating to benefits for individuals who perform substantial gainful activity despite severe medical impairment).

* * * * *

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

* * * * *

PART 4—PEER REVIEW ORGANIZATIONS

* * * * *

Subtitle B—Medicaid and Maternal and Child Health

* * * * *

SEC. 9506. TREATMENT OF POTENTIAL PAYMENTS FROM MEDICAID QUALIFYING TRUSTS.

(a) * * *

* * * * *

(c) *EXCEPTION.*—*The amendment made by subsection (a) shall not apply to any trust or initial trust decree established prior to April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.*

* * * * *

SEC. 9517. MODIFYING APPLICATION OF MEDICAID HMO PROVISIONS FOR CERTAIN HEALTH CENTERS.

(a) * * *

* * * * *

(c) HEALTH INSURING ORGANIZATIONS. * * *

(2)(A) Except as provided in subparagraph (B), the amendments made by paragraph (1) shall apply to expenditures incurred for health insuring organizations which first become operational on or after January 1, 1986.

For purposes of this paragraph, a health insuring organization is not considered to be operational until the date on which it first enrolls patients.

* * * * *

(B) In the case of a health insuring organization—

(i) which first becomes operational on or after January 1, 1986, but

(ii) for which the Secretary of Health and Human Services has waived, under section 1915(b) of the Social Security Act and before such date, certain requirements of section 1902 of such Act,

clauses (ii) and [(iv)] (vi) of section 1903(m)(2)(A) of such Act shall not apply during the period for which such waiver is effective.

(C) *In the case of the Hartford Health Network, Inc., clauses (ii) and (vi) of section 1903(m)(2)(A) of the Social Security Act shall not apply during the period for which a waiver by the Secretary of Health and Human Services, under section 1915(b) of such Act, of certain requirements of section 1902 of such Act is in effect (pursuant to a request for a waiver under section 1915(b) of such Act submitted before January 1, 1986).*

* * * * *

SEC. 9528. ANNUAL CALCULATION OF FEDERAL MEDICAL ASSISTANCE PERCENTAGE.

(a) ANNUAL CALCULATION.—Section [1101(a)(8)(P)] 1101(a)(8)(B) of the Social Security Act is amended—

(1) by striking out “even-numbered”; and

(2) by striking out “eight quarters” and inserting in lieu thereof “four quarters”.

* * * * *

(c) *HOLD HARMLESS PROVISION.*—*Notwithstanding subsection (b), for calendar quarters occurring during fiscal year 1987 and only for purposes of making payments to States under sections 403 and 1903 of the Social Security Act, the amendments made by subsection (a) shall not apply to a State if the effect of the applying the amendments would be to reduce the amount of payment made to the State under that section.*

OMNIBUS BUDGET RECONCILIATION ACT OF 1981

* * * * *

Subtitle C—Provisions Relating to Medicaid

* * * * *

CHAPTER 2—INCREASED FLEXIBILITY FOR STATES

* * * * *

REIMBURSEMENT OF HOSPITALS

SEC. 2173. (a)(1) * * *

* * * * *

(d) *Section 1902 of such Act is further amended by inserting before subsection (i) the following new subsection:*

“(h) *Nothing in this title (including subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payments that may be made under a plan under this title with respect to inpatient hospital services, skilled nursing facility services, or intermediate care facility services, including any such limitation relating to the amount that can reasonably be estimated would have been paid for such services under the reimbursement principles applicable under title XVIII.*”

MINORITY VIEWS ON MEDICARE AND MEDICAID RECONCILIATION AMENDMENTS FOR FISCAL YEAR 1987

We are compelled to register our strong opposition to the Committee's Medicare and Medicaid Budget Reconciliation Legislation for Fiscal Year 1987. This bill falls far short of achieving the savings required by the Budget Resolution (S. Con. Res. 120) adopted by both the House and Senate on June 26, 1986. The minimal savings that are achieved through changes to the Medicare program are significantly reduced by many provisions which will increase Federal spending in both of the entitlement programs under the Committee's jurisdiction. There may be merit to the spending proposals contained in this legislation, but a reconciliation bill is an inappropriate context in which to incorporate them.

The Committee on Energy and Commerce's budget reconciliation instructions included in the Budget Resolution for FY 1987 called for savings in the Medicare program of \$500 million in 1987 and \$3.25 billion over a three year period. Although the budget does not specify how this savings target is to be achieved, it does assume that provider reforms will be enacted that will not increase beneficiary costs or reduce services. As in past years, the reconciliation instructions regarding the Medicare program are the same for both the Committee on Ways and Means and the Committee on Energy and Commerce. The Budget Committee assumes that the two Committees will jointly meet the savings targets through reforms to the portions of the Medicare program under each Committee's jurisdiction.

S. Con. Res. 120 does provide for certain expansions to the Medicaid program and the Maternal and Child Health (MCH) Block Grant, but it does not specify that these changes should be part of the Committee's reconciliation package. Without specific instructions, we believe it is inappropriate for this or any other Committee to use legislation that is purposefully drafted to achieve savings in a program as a vehicle for authorizing new spending in a different program. Separate legislation expanding the Medicaid and MCH Block Grant, following the usual Committee hearing process would be given careful consideration by this Committee. In fact, many of us would support some of these changes, if taken up separately. By including these Medicaid and MCH Block Grant expansions in the Committee's budget reconciliation bill, they are not voted on based on their own merits. In addition, if the reconciliation bill is taken up on the Floor under a closed rule, which is quite often the case, no future opportunity to offer amendments is afforded Members.

The so-called Medicare "reforms" included in the Committee's package represent a set of choices between spending and savings measures to which we are unwilling to be a party. Following a year in which the Gramm-Rudman legislation reduced Medicare pay-

ments to hospitals and physicians by 1% and the enactment of the FY 1986 reconciliation legislation which found close to \$3 billion in Medicare savings, any further reductions to providers should be carefully analyzed. Although we believe that program savings are achievable, these savings should not be found in order to expand the same program in other areas: such is the case in the Committee's Medicare and Medicaid Package. For example, we must question the fairness of reducing payments for services provided to renal dialysis patients, cataract patients and patients in need of oxygen therapy, in exchange for expanding coverage for occupational therapy and judicial review of Part B claims. This practice of cutting funds for one service in order to expand another cannot be considered responsible Congressional action.

Also, this Committee should not repeatedly rely on the Committee on Ways and Means to find the savings that both Committees were jointly instructed to achieve. The Medicare Part A program which provides reimbursement for hospital services has been subjected to significant reductions in payments over the past three years. Making further cuts in hospital reimbursement in order to expand outpatient services covered under Medicare Part B, only enhances the inequities to Medicare beneficiaries established by this Committee's bill.

We are very much aware of a rule in the Senate which prohibits the inclusion of extraneous materials in reconciliation legislation. Extraneous material can include provisions which increase outlays or decrease revenues or do not affect outlays and revenues if a Committee's bill or title of a bill fails to achieve the Committee's reconciliation instructions. In the Senate, a "point of order" may be raised against this extraneous material in a conference report as well as in a House amendment. Clearly, this Committee's health package could be subject to such a point of order.

The budget process is meaningless if the Committee on Energy and Commerce, or any other Committee in Congress, refuses to take seriously the instructions for reconciliation provided by the Resolution. Spending measures should be considered by the Committee in separate legislation, not tacked on to a savings measure, keeping the Committee from reaching its budget reduction targets.

The Medicare and Medicaid Amendments approved by this Committee on July 23, 1986 fall far short of the deficit reduction goal assigned to this Committee by S. Con. Res. 120. This package is an inappropriate budget reconciliation bill that could possibly subject the Conference Report or a House amendment to a point of order.

We believe this Committee has an obligation to the American people to make real contributions to cutting the deficit. Unfortunately, the bill our colleagues voted to report to the House is not a legitimate savings proposal, and we must voice our opposition.

NORMAN F. LENT.

ED MADIGAN.

CARLOS J. MOORHEAD.

BILL DANNEMEYER.

JACK FIELDS.

MICHAEL G. OXLEY.

HOWARD C. NIELSON.

DAN SCHAEFER.

TRENT LOTT.

Corporation may terminate the revolving fund at an earlier date if the Administration certifies to the Corporation that all net losses on guaranteed securities purchased by the Corporation under section 361 of the Act have been paid and that there will be no net losses in the future under subsection (b) above. Any balances remaining in the revolving fund at the time of termination shall be distributed as follows: seventy-five per centum to the capital surplus account of the Corporation and twenty-five per centum to the Trust created under section 359 of the Act.

Section 6. This section makes technical amendments to the provisions of section 4(c)(5)(of the Small Business Act governing financing functions under that Act and the Small Business Investment Act of 1958; and provides that SBA is relieved of further interest payment obligations to the Treasury on SBIC debentures sold to COSBI.

Section 7. This section amends section 5(b)(2)(of the Small Business Act to prohibit sale of small loans and debentures except by provisions of section 361 of the Small Business Investment Act of 1958.

Section 8. This section is a technical amendment to section 321 of the Small Business Investment Act of 1958 and to section 18005 of the Consolidated Omnibus Budget Reconciliation Act of 1985 of 1985, P.L. 99-272, to correct an error in the enrolling of the bill that became P.L. 99-272.

Section 9. The sixth sentence of the seventh paragraph of section 5136 of the Revised Statutes of the United States (12 U.S.C. 24) is amended by inserting after "Student Loan Marketing Association" the following: "or obligations or other instruments or securities of the Corporation for Small Business Investment", thereby adding these securities to the permitted purchase list.

Section 10. This section provides that the powers and functions of the Corporation and its Board of Directors shall be exercisable, and the provisions of the Act shall be applicable and effective, without regard to any other law.

Section 11. Territorial Applicability. This section provides that, notwithstanding any other law, the Act is applicable to the several States, the District of Columbia, the Commonwealth of Puerto Rico, and any other territories, possessions and dependencies of the United States.

TITLE X—COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC, July 28, 1986.

Hon. WILLIAM H. GRAY III,
*Chairman, Committee on the Budget, U.S. House of Representatives,
Washington, DC.*

DEAR MR. CHAIRMAN. Pursuant to the reconciliation instruction contained in S. Con. Res. 120, I am transmitting the recommendations of the Committee on Ways and Means approved in our markup on July 23. As you requested, enclosed are the legislative language, explanatory material and report language, CBO cost estimates of the legislation, and additional views.

Total deficit reduction achieved by the Committee from Fiscal Year 1987 to 1989 is \$12.0 billion. This is \$.4 billion more than the budget resolution assumed. Concerns have been raised about the fact that the 1987 deficit target was not met. Given Gramm-Rudman and the potential sequester order which might result, these concerns are legitimate. Consequently, I will make every effort to ensure that the target for Fiscal Year 1987 will be achieved.

By a unanimous vote of the Committee, I have been directed to seek a closed rule on the title of the reconciliation bill which contains the recommendations of the Committee on Ways and Means.

If you have any questions, please contact Committee staff.

Sincerely,

DAN ROSTENKOWSKI, *Chairman.*

REPORT TO ACCOMPANY RECOMMENDATIONS FROM THE COMMITTEE ON WAYS AND MEANS

I. SUMMARY

Subtitle A—Social Security Provisions

(1) *Eliminate the COLA Trigger.*—The bill would eliminate the requirement that the increase in the CPI must reach three percent before a COLA is provided to social security beneficiaries. The provision would, therefore, ensure that a social security benefit increase will be paid in the January, 1987, benefit checks. This provision would have the effect of eliminating the trigger for several other automatic adjustments that increase only if a social security COLA is provided (e.g., the FICA wage base, the medicare part B beneficiary premium, and SSI, railroad retirement, and Veterans' pension COLAs).

(2) *State and Local Deposits.*—The bill would relieve the States of the responsibility for collecting the social security contributions of its political subdivisions, and would place all State and local government employers under a depositing schedule that conforms with the frequency required of private employers. This provision would be effective January 1, 1987.

Subtitle B—Public Assistance and Unemployment Compensation Provisions

(1) *Aid to Families With Dependent Children (AFDC) for Unemployed Two-Parent Families (AFDC-UP).*—The bill requires all State AFDC programs to offer coverage to financially eligible two-parent families in which the principal earner is "unemployed," defined as working fewer than 100 hours per month. This is currently a State option. Twenty-four States and two territories do not now provide AFDC to such families.

(2) *Annual Calculation of the Federal Percentage of AFDC Expenditures.*—P.L. 99-272 requires an annual rather than biennial calculation of the Federal AFDC percentage beginning in FY 1987. This results in a loss of AFDC funds to 13 States. The bill restores these funds for FY 1987 only.

(3) *Income and Eligibility Verification System*.—Section 1137 of the Social Security Act requires States to establish an income and eligibility verification system for certain public assistance programs. Under the system, States must request and make use of quarterly wage data and unearned income data supplied by the Internal Revenue Service (IRS). The bill clarifies that Congress intends that the system be targeted to those uses which are likely to be most productive. States would be permitted to prioritize and target the follow-up and review of case records based on the information supplied.

(4) *Two-Year Extension of Temporary Federal Unemployment Tax (FUTA)*.—Generally, employers pay FUTA tax of .8% on the first \$7,000 in wages paid to an employee. Under current law, the tax will automatically decrease to .6% on January 1, 1988. The bill would extend the tax at the .8 percent rate for two years.

Subtitle C—Medicare and Health Programs

(1) *Limit Increase in Part A Deductible*.—For calendar year 1987, the hospital deductible would be \$500. In future years, current law would prevail.

(2) *Hospital Rate of Increase*.—Hospitals would be provided a 1.3% increase in the prospective payment rates for FY 1987 and an increase of the hospital market basket minus 2.0% for FY 1988.

Hospitals exempt from the prospective payment system would be provided a 1.3% increase in the cost limits for FY 1987, and an increase hospital market basket minus 2.0% for FY 1988.

The Secretary of Health and Human Services (HHS) would be required to recalibrate the Diagnostic Related Groups (DRG's) annually.

(3) *Capital Reimbursement under Medicare*.—The rate of increase in aggregate capital expenditures for inpatient hospital services would be capped. The rate of increase for FY 1987 would be limited to aggregate expenditures in FY 1986 plus 10%. The rate of increase for FY 1988 would be limited to aggregate expenditures in FY 1986 plus 20%, and the increase in FY 1989 would be limited to aggregate expenditures in FY 1986 plus 30%. This provision would only apply to PPS hospitals.

(4) *Include Puerto Rico into the Prospective Payment System (PPS) with Appropriate Adjustments*.—The Secretary would be required to include Puerto Rico in the prospective payment system. The rates would be established at a 75% Puerto Rico-specific standardized rate and a 25% national standardized rate.

The Secretary would be required to base the Puerto Rico-specific payments on urban and rural standardized rates. Additional adjustments would be made for indirect teaching costs and for eligible disproportionate hospitals.

The Secretary would be prohibited from restandardizing the national DRG rate to reflect Puerto Rico's inclusion into the prospective payment system.

(5) *Quality Protection*.—The Secretary would be required to develop a plan to refine the prospective payment system for hospitals to adjust for severity of illness. Hospitals would be required to provide a statement of patient rights to beneficiaries. Beneficiaries would

have a right to appeal hospital discharge notices and would not be liable for continued inpatient stay until after the appeal is decided. Hospitals, health maintenance organizations (HMO's), and competitive medical plans (CMP's) would be prohibited from paying physicians to reduce or limit services to beneficiaries. The prohibition would be effective for hospitals six months after enactment and would be effective for HMO's and CMP's on January 1, 1988. HHS would be required to submit a report to Congress by April 1, 1987, concerning appropriate exceptions to the prohibition for HMO's and CMP's. HHS would be required to study the adequacy of medicare's quality assurance standards for hospitals and the need for payment for administratively necessary days.

Hospitals would be required to provide discharge planning. The favorable presumption of the waiver of liability for medical necessity and custodial care denials for hospice, home health and skilled nursing facility services would be extended through September 30, 1989. A waiver of liability would be established for homebound and intermittent care denials for home health services, and a favorable presumption for these denials would be effective through September 30, 1989. HHS would be required to develop a uniform needs assessment instrument and would be required to develop an expedited review process for post-hospital services. Providers would be allowed to bring appeals on behalf of beneficiaries; appeals of technical denials would be allowed. HHS would be required to include information concerning quality in its annual report on prospective payment and would be required to conduct a demonstration project concerning prior authorization for home health and skilled nursing facility services.

HHS would be required to ensure that Peer Review Organizations (PRO's) receive data needed to conduct reviews on a timely basis. PRO review of early readmission cases would be expanded. Each PRO would be required to provide for a reasonable allocation of its quality review effort among all medicare providers. PRO's would be required to appoint a consumer representative to their executive boards and would be required to investigate written complaints about quality of care. Confidential information obtained by PRO's could be shared with national accreditation bodies and with long-term care ombudsmen and state protection and advocacy officials. PRO funding would be increased to cover the cost of the new PRO activities.

HHS would be required to contract with the Institute of Medicine to conduct a study to assist in the development of a long-term strategy for quality assurance.

(6) *Hospital Insurance Trust Fund Off-Budget in 1987.*—The effective date of the provision of the Social Security Act that removes the receipts and disbursements of the Federal Hospital Insurance Trust Fund from the unified budget would be accelerated from FY 1993 to FY 1987.

(7) *Eliminate Periodic Interim Payments (PIP) with Prompt Pay for Providers.*—The periodic interim payment would be eliminated effective July 1, 1987, for all hospitals for inpatient services except for services provided in "disproportionate share" hospitals, sole community hospitals and PPS-exempt hospitals and units. Furthermore, other cost-based providers would continue to receive periodic

interim payments. The Secretary would be required to make advance payments to hospitals, if the hospital can demonstrate that elimination of the PIP option is causing significant financial difficulty.

The Secretary would be required to pay Part A "clean" claims within 22 calendar days of receipt beginning on July 1, 1987. "Clean" claims submitted by participating physicians and suppliers would be required to be paid within 11 days beginning in FY 1988, and within 22 days for nonparticipating physicians and suppliers beginning in FY 1988.

If the claim is not paid in the required time period, a notice must be sent to the beneficiary, physician, supplier or provider submitting the claim to inform them of expected delays. If the claim is not paid or a notice mailed, interest would begin to accrue on the day following the day on which payment was due.

(8) *Health Maintenance Organization Amendments.*—The HMO amendments include provisions regarding, (a) composition of enrollment, (b) authority to impose civil monetary penalties, (c) a study on the adjusted average per capita cost and the adjusted community rate, (d) prompt payment of claims, (e) allowing beneficiaries to disenroll from an HMO at a local Social Security Office, (f) allowing the Health Care Finance Administration (HCFA) access to financial records of subcontractors of HMO's and CMP's and (g) requiring provision of an explanation of patient rights.

(9) *Eliminate Health Maintenance Organization Two for One Rule.*—The requirements that HMO's that had or have a medicare cost contract but which sign a section 1876 risk contract must enroll two new medicare risk contract enrollees before they can convert one medicare cost contract member would be deleted.

(10) *Extend Part B 25% Premium Policy for One Year.*—The existing temporary provision of law whereby the portion of part B program costs financed by premium income equals 25% would be extended for one additional year, through calendar year 1989.

(11) *Extend and Modify Limits on Physicians Fee Increases.*—On January 1, 1987, all physicians will receive an increase equal to the Medical Economic Index (MEI) (now estimated to be 3.2%) in prevailing charges above levels in effect during 1986. In future years, all physicians will receive an increase in prevailing charges equal to the MEI. Participating physicians would receive an additional 1% bonus in 1987 and an increase equal to the MEI in 1988 and 1989. The 1 percent would not be included in the base and would not compound in future years.

Nonparticipating physicians could increase their actual charges by the MEI plus 1% in 1987 and by the MEI in 1988 and 1989. The 1% would be included in the base and would compound in future years. Special rules apply for new nonparticipating physicians. The Secretary would be prohibited from revising the MEI on a retrospective basis.

(12) *Programs to Increase Physician Participation.*—A directory of participating physicians would be sent to each beneficiary starting in 1988. Carriers would be required to implement programs to recruit participating physicians and to familiarize beneficiaries with the participating physician program. An incentive pool would be available for distribution to carriers based on their success in re-

cruiting new participating physicians. The medicare provider agreement for hospitals would be amended to require that hospital personnel provide the name of at least one qualified participating physician when referring a beneficiary for follow-up care on an outpatient basis. Physicians would be prohibited from charging for unnecessary services, whether or not assignment is accepted. Physicians providing high-cost elective surgical procedures on an unassigned basis would be required to provide fee information to the beneficiary in advance of performing the procedure.

(13) *Prohibit Administration Regulation on Overpriced Procedures and Require Study.*—The Secretary would be prohibited from using “inherent reasonableness” to establish special reasonable charge limitations for services covered under medicare part B. Payment rates would continue to be determined on the basis of actual, customary and prevailing charges. The Secretary would be required to submit a report to Congress, after consultation with the Physician Payment Review Commission, concerning payment reductions for overpriced procedures.

(14) *Reduce Rates to End-Stage-Renal-Disease (ESRD) Facilities and Physicians and Strengthen Networks.*—The facility composite payment rate would be reduced by approximately \$5.50 per treatment (4.5%) based upon more recent data on facility mix, and home/in-facility dialysis mix. The base rate could be no lower than \$117.50 for free-standing ESRD facilities and no lower than \$121.50 for hospital based facilities.

The monthly capitated payment rate for physicians treating ESRD patients would be reduced by approximately \$14 (8%) to reflect the shorter period of time spent on patients who receive their care at home.

The Secretary would be required to establish 17 or more networks to carry out the functions and responsibilities as presently set forth in law, and the responsibilities of the networks would include: (a) collecting, validating and evaluating patient and facility data; (b) conducting on-site review of the medical care provided to beneficiaries in facilities; and (c) implementing a procedure for evaluating and resolving patient grievances.

(15) *Technical Amendments and Miscellaneous Provisions.*—The provision corrects a number of technical errors in the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, and related laws including the disproportionate share, indirect teaching adjustment, prospective payment for skilled nursing facilities, assistants at surgery and direct medical education provisions.

In addition, there are eight other non-cost provisions which would:

(a) Extend the Secretary's authority to enter into two competitively bid contracts under parts A and B of medicare to replace poor performing contracts for three years;

(b) Modify the effective date of disenrollment from medicare when a beneficiary files a notice to disenroll;

(c) Legalize the payment of administrative fees to group purchasing organizations for vendors where full disclosure of such payment is made;

(d) Expand the membership of the Physician Payment Assessment Commission to 13;

(e) Provide a one-year extension of the "pass through" for costs for services of certified registered nurse anesthetists;

(f) Connecticut Hospice, Inc. would be waived for two years from the 80/20 inpatient/home care day requirement. Connecticut Hospice would not be allowed to have more than 50% of total days as inpatient days.

(g) The three-year period granted for rural referral centers status would be extended to four years; and

(h) Require that the Secretary of HHS may not recoup from nor reduce payments to Massachusetts hospitals until January 1, 1988.

(16) *High Risk Health Insurance Pools.*—Once a State has established a health insurance pool, any employer with 20 or more employees who does business in the State, would be required to participate in the insurance pool or face a 5% excise tax on gross wages (as defined in Internal Revenue Code sec. 3401) paid or incurred during the taxable year. To the extent the insurance pool is not self-supporting from premiums, losses would be made up by equitable assessments on all participating employers in the State.

The health insurance pool would be available to all residents of the State regardless of health status. Policies would be designed to offer coverage typical of large employer plans in the State, but premiums charged, in no event, could be higher than 150% of average premium rates for individual standard risks in the State for comparable coverage. Coverage standards would be established for lifetime limits, caps on out-of-pocket expenses, deductibles, coverage for pre-existing conditions and durable medical equipment. A State or other entity could provide payment of part or all of the premium of an enrollee and could vary the amount of the payment based on the enrollee's income or on some other basis.

State Legislatures would have until January 1, 1988, to establish a health insurance pool or until the first January 1st that occurs after the close of their first regular State legislative session.

(17) *Technical Corrections Concerning Private Health Insurance Continuation Coverage.*—There are several technical corrections which would:

(a) Establish a 60-day notification deadline for divorced and legally separated spouses and dependents who no longer qualify as dependents under the plan's definition.

(b) Clarify that a qualified beneficiary may have more than one qualifying event, but the length of coverage could not exceed 36 months;

(c) Clarify that an election by a qualified beneficiary shall be deemed to be an election for all other qualified beneficiaries in the family, but each qualified beneficiary is entitled to make an individual election;

(d) Specify a 30-day period of time (or longer if the plan permits) for which failure to pay the premium would result in termination of coverage;

(e) Clarify that if coverage is modified for all similarly situated beneficiaries, coverage shall be modified for qualified beneficiaries.

(18) *Extend the Private Health Insurance Continuation Coverage.*—The Consolidated Budget Reconciliation Act of 1985 (COBRA)

provision would be amended so that in the event that an employer files for Chapter 11 reorganization on or after July 1, 1986, all the retirees, regardless of the date of retirement, their spouses and dependents, who would lose their employer-based health insurance would have the option to elect to continue in the employer based health insurance plan until the death of the retiree, reemployment, remarriage resulting in coverage from the spouse's plan, or failure to pay the premium. Upon the death of the retiree, the widow and dependents could elect to remain in the health plan for up to three years as defined in COBRA.

Subtitle D—Revenue Provisions

(1) *Extension of Telephone Excise Tax.*—Under current law, a three-percent excise tax is imposed on amounts paid for local telephone service, toll telephone service, and teletypewriter exchange service. This excise tax is currently scheduled to terminate after December 31, 1987. Under the new provision adopted by the Committee, it would be extended at a three-percent rate for two years, through December 31, 1989.

SUMMARY OF DEFICIT REDUCTION

The net deficit reduction achieved by the provision summarized above, over the three-year period from 1987–1989, is \$12.0 billion, as shown in the attached table. The deficit reduction target for the Committee on Ways and Means in the House-passed budget resolution is a net of \$11.6 billion. This includes \$12.6 billion in deficit reduction and \$1.0 billion in allowed spending.

Deficit reduction achieved from FY 1987–89

	<i>Millions</i>
A. Budget resolution targets:	
Reconciliation instruction	\$12,635
Allowed spending	(1,000)
Net deficit reduction	11,635
B. Committee recommendations:	
Social Security:	
Remove COLA trigger	
Accelerate State and local deposit of payroll taxes	1,846
Public assistance:	
AFDC-UP	(370)
FY 1987 Federal AFDC Percentage	(15)
IEVS targeting	
FUTA repayment tax extension	2,150
Medicare:	
Set hospital deductible at \$500 in 1987	(810)
Hospital payment increases of 1.3 percent for FY 1987 and market basket minus 2.0 percent for FY 1988	2,670
Limit aggregate capital payment increases to 10 percent annually	1,100
Include Puerto Rico into PPS system	(45)
Quality protections	(362)
Medicare off-budget in 1987	
Eliminate periodic interim payments with prompt pay for providers	1,621
HMO amendments	
Eliminate HMO 2-for-1 rule	(120)
Extend part B 25 percent premium policy for 1 year	440
Extend and modify limits on physicians fee increases	(50)

	<i>Millions</i> (¹ 200)
Programs to increase physician participation.....	
Disallow administration regulation on overpriced procedures and require study.....	
Reduce rates to ESRD facilities and physicians and strengthen networks.....	297
Technical amendments and miscellaneous provisions.....	
High risk health insurance pools.....	
COBRA health insurance amendments.....	
Revenues: Extend telephone excise tax for 2 years.....	3,627
Total (Net Deficit Reduction).....	11,978

¹ Not included in totals. Dollar amounts determined by appropriation action.

Note: Numbers in parentheses indicate the provision will cost, not save money.

II. EXPLANATION OF PROVISIONS

Subtitle A.—Social Security Amendments

1. Elimination of 3-Percent Trigger for Cost-of-Living Increases (sec. 10001 of the bill)

Present law.—The Social Security Act provides for a cost-of-living adjustment (COLA) for benefits under the Old-Age, Survivors, and Disability Insurance program, based on the consumer price index (CPI), if the CPI increases by 3.0 percent or more during a specified base period (currently, the third quarter of the prior year through the third quarter of the current year). If the CPI rises by less than 3.0 percent during the base period, a COLA is not provided. In the following year, however, the COLA is based on the accumulated increase in the CPI over 2 years.

Several other automatic increase provisions are linked to the social security COLA, and are triggered only if the social security COLA is provided. These include the increase in: a) the maximum amount of earnings taxable under FICA and SECA; b) the amount of earnings exempt from the retirement test; c) the Supplementary Medical Insurance (SMI) beneficiary premium; d) railroad retirement, Supplemental Security Income (SSI), and Veteran's pension benefits; and e) certain eligibility standards for medicaid, food stamps, housing assistance, and Aid to Families with Dependent Children (AFDC).

Explanation of provision.—The Committee bill would eliminate the 3 percent trigger for the provision of the social security COLA. A COLA would be provided in any year in which there has been a positive rise in the CPI during the specified base period. This would have the effect of assuring that the other automatic increase provisions linked to the Social Security COLA would also rise in any year in which the CPI rises.

This provision also contains a technical amendment to the SMI program to clarify that in implementing the SMI "hold harmless" provision (mandated by the Deficit Reduction Act of 1984) that the proceeds from rounding social security benefit amounts down to the next lower dollar accrue to the OASDI trust funds.

Effective date.—This provision will be effective for the COLA provided in December 1986.

2. *Deposits of Social Security Contributions by State and Local Government Employers (sec. 10002 of the bill)*

Present law.—Each State may enter into a voluntary agreement with the Secretary of Health and Human Services to provide social security coverage for employees of the State government and any of its political subdivisions. A State which enters into a coverage agreement is liable for collecting and depositing with the Federal government twice a month employer and employee social security contributions on their own behalf and for sub-State entities. Payments of social security contributions are first made by the local subdivisions to the State, which also is responsible for verifying and consolidating the payments. The State then deposits with the Federal Government these payments and the appropriate amounts with respect to its own employees.

Private employers are required to make payroll tax payments under a schedule that links the frequency of deposits to the amount of taxes withheld. Large employers may make deposits as frequently as eight times a month, while small employers may make them as infrequently as once every 3 months. (These rules also apply to deposits of Federal income taxes withheld by State and local governments from their employees.)

Late deposits by State governments are subject to an interest charge at the rate of 6 percent per year. Private sector employers pay an interest rate that is based on the prime interest rate charged by major commercial banks. This rate is adjusted semi-annually.

Explanation of provision.—The Committee bill removes from the States the intermediary role of collecting social security contributions from sub-State entities and place all State and local government employers under a direct depositing requirement with a schedule that conforms with the frequency required of private employers. State are relieved of liability for collecting and verifying the social security contributions owed by its political subdivisions. In addition, the provision subjects State and local governments to the same interest charge and penalties for late deposits as are imposed on private employers.

Effective date.—The provision is effective for payments of contributions due with respect to wages paid after December 31, 1986.

Subtitle B.—Public Assistance and Unemployment Compensation Provisions

1. *AFDC for Unemployed Two-Parent Families (sec. 10101 of the bill)*

Present law.—States have the option to provide AFDC to financially eligible two-parent families in which the principal earner is “unemployed,” defined as working fewer than 100 hours per month.

For eligibility, the law requires that the unemployed parent have worked 6 or more quarters in any 13-calendar quarter period ending within 1 year before applying for AFDC-UP.

States without an AFDC-UP programs are: Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Georgia, Idaho, Indiana,

Kentucky, Louisiana, Mississippi, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, Utah, Virginia, and Wyoming. The Virgin Islands and Puerto Rico also do not have AFDC-UP.

Explanation of provision.—The bill requires all State AFDC programs to offer assistance to financially eligible two-parent families in which the principal earner is “unemployed,” defined as working fewer than 100 hours per month.

In addition, the definition of “quarters of work” would be modified. States would be permitted to substitute for 4 of the requisite 6 quarters of work, quarters of full-time attendance in elementary or secondary school or full-time participation in vocational training, with a lifetime limit of 4 quarters creditable to vocational training.

Effective date.—The proposal would be effective January 1, 1988.

2. *Targeting the Use of the Income and Eligibility Verification System (sec. 10102 of the bill)*

Present law.—Section 1137 of the Social Security Act requires that States establish an income and eligibility verification system (IEVS) for certain public assistance programs. Section 1137 was established by the Deficit Reduction Act of 1984 and was effective April 1, 1985, although the Secretaries of the respective departments may permit States to delay implementation. Such delays may not extend beyond September 30, 1986.

Under IEVS, the State agencies administering AFDC, Medicaid, Unemployment Compensation, Food Stamps and the adult assistance programs in the territories (and the Social Security Administration (SSA) in the case of the SSI program) must request and make use of: (1) unearned income information available from the Internal Revenue Service; and (2) quarterly wage information. Independent verification of the unearned income information is required before action can be taken and recipient confidentiality must be protected.

Explanation of provision.—The bill clarifies that Congress intends that the system be targeted to those uses which are likely to be most productive.

It is the intent of the Committee to have States utilize a variety of information sources to verify the eligibility of applicants and recipients of benefit programs, as an effective and efficient tool in preventing benefit payments from being made to individuals who are not eligible. For the use of such information to be a productive activity, States must be afforded the discretion to target their efforts in ways they determine most cost effective. The final rules promulgated by the respective Departments do not permit the targeting prescribed in statute. Rather, the final rules call for matching all applicants and recipients against each information source, and require a follow-up in all cases where any income, earned or unearned, is indicated. This universal review was not what was intended by Congress and would result in an unnecessary and costly administrative burden on the States.

To insure that the required matches are cost-effective verification processes, the States should be allowed to prioritize and target the follow-up of case records based on match findings. For example, following-up on individuals whose unearned income exceeds certain

tolerance levels is more efficient than verifying every case with unearned income.

In addition, the Committee believes that requiring States to act upon the information they receive within 30 days, as prescribed in the final rule, is unrealistic. States have a finite amount of administrative resources, and are dependent upon the actions of others outside the agency as well as the mail system to carry out their duties. For this reason, the Committee believes a 45 days requirement is more reasonable than the 30 days set forth in the final rule. The allowance that action can be delayed further on up to 20 percent of the information items when collateral verification sources are required—as provided in the final rules—should be retained.

Effective date.—On enactment.

3. Annual Calculation of the Federal Percentage of AFDC Expenditures (sec. 10103 of the bill)

Present law.—Prior to enactment of Public Law 99-272, the Federal percentage was calculated between October 1 and November 1 of each even-numbered year. The percentage applied to the two year period beginning the following October. P.L. 99-272 requires an annual rather than biennial calculation of the Federal percentage beginning in FY 1987.

Explanation of provision.—The shift from a biennial to an annual calculation of the Federal percentage occurs in the middle of the two-year cycle and results in a loss of funds for 13 States in FY 1987. The bill restores these funds for FY 1987 only. According to the Department of Health and Human Services the States affected are: Arizona, Florida, Georgia, Maine, Minnesota, Missouri, New Hampshire, North Carolina, Ohio, Rhode Island, South Carolina, South Dakota, and Virginia.

Effective date.—October 1, 1986.

4. Extension of that Portion of the Federal Unemployment Tax (FUTA) that is Due to Expire on December 31, 1987 (sec. 10104 of the bill)

Present law.—Employers pay a FUTA tax of 6.2% on the first \$7,000 in wages paid to their employees. They receive a credit, however, of 5.4% in recognition of the State unemployment taxes that they pay, making the net FUTA tax .8%. A portion of the 6.2% gross FUTA rate, .2%, is temporary and under current economic assumptions will expire on December 31, 1987. This will reduce the net FUTA tax to .6%.

The temporary portion of the FUTA tax was enacted as part of the Unemployment Compensation Amendments of 1976 (P.L. 94-566) and became effective on January 1, 1977. The funds generated by this portion of the tax are used to repay general revenue advances made to the Extended Unemployment Compensation Account. These advances have been used to pay for the Federal Supplemental Benefit program and for the Federal share of the permanent extended benefit program.

Under current law, the tax automatically expires at the beginning of the first year following the year in which the advances are repaid. Current economic projections indicate that advances will be

fully repaid in mid-1987. This means that the gross FUTA tax rate will be 6.0% and the net FUTA tax rate will be .6%, for the year beginning January 1, 1986.

Explanation of provision.—The bill provides that the temporary FUTA tax would remain in effect for 1988 and 1989, notwithstanding the anticipated repayment in 1987 of general revenue advances to the Extended Unemployment Compensation Account.

Effective date.—The provision applies to remuneration paid after December 31, 1986.

Subtitle C.—Medicare and Health Programs

Part 1—Provisions Relating to Medicare Part A Only

1. Setting part A deductible at \$500 for 1987 (sec. 10201 of the bill)

Present law.—Under current law medicare beneficiaries are required to pay a part A hospital deductible for each hospital admission, but not to exceed one hospital deductible per spell of illness. The part A deductible is tied to a formula based on the annual increase in the average cost per day of hospitalization. The deductible for CY 86 is \$492 and is projected to rise to \$572 in 1987, \$616 in 1988, and \$648 in 1989. The part A deductible has increased rapidly as an unforeseen consequence of the shorter lengths of stay that have resulted in part from the implementation of the prospective payment system for hospitals.

Explanation of provisions.—For CY 86 the hospital deductible would be \$500, thereafter current law would prevail. The Committee believes that the projected increases in the hospital deductible are unacceptably high and will reach levels which were never intended. If the current rate of increase had been allowed, the part A deductible would have gone up 43% over the two years, 1986–1987. For this reason, the Committee has decided to set the deductible at \$500 for CY 86 with the thought that it will revisit this issue next year to determine an appropriate rate structure for future years.

Effective date.—The provision is effective for part A hospital deductibles incurred in 1987.

2. Applicable percentage increase in payments for inpatient hospital services (sec. 10202 of the bill)

Present law.—Current law provides that the medicare prospective payment rates be updated annually by the Secretary of Health and Human Services (HHS). The law states that the update should reflect increases in hospital input prices, but not to exceed the hospital market basket (index measuring hospital input prices) for FY 1987 and FY 1988 and market basket plus one quarter of a percentage point thereafter. The Congressional Budget Office baseline for estimating FY 1987 expenditures assumes a 2% increase in payments for PPS hospitals.

On June 30, 1986, the Secretary of HHS promulgated proposed regulations that would provide a .5% increase in the prospective payment rates for FY 1987. The Prospective Payment Assessment Commission (ProPAC) has recommended a 2.2% increase in prospective payment rates for FY 1987 if capital is included into the PPS system, 1.9% if not.

PPS-exempt hospitals are paid on a cost basis subject to caps on the maximum amount of allowable reimbursement. The Secretary of HHS has proposed a .5% increase in the caps of PPS-exempt hospitals while ProPAC has recommended a 3.2% increase.

Current law requires that the DRG weights by recalibrated no less frequently than every four years. Recalibration means the adjustment of all DRG weights to reflect relative resource use associated with all existing DRG categories and/or the creation or elimination of DRG categories.

Explanation of provision.—The bill would require that prospective payment system hospitals be provided a 1.3% increase in the average standardized payment amounts for fiscal 1987 and market basket minus two percentage points for fiscal 1988.

PPS-exempt hospitals would be provided a 1.3% increase in the cost limits for FY 1987, and an increase for hospital market baskets minus 2.0% for FY 1988. In years beyond FY 1988 the bill would indicate that the update factor for PPS hospitals may be established at a different level than the update factor for PPS exempt hospitals. It is the Committee's view that the criteria utilized to develop the update factor for PPS-exempt hospitals should be specific to the operation of these facilities. Therefore, the Committee recommends that the Secretary consider the ProPAC recommendations regarding a separate update factor for PPS-exempt hospitals.

The Committee has given, in the past, a significant amount of discretion to the Secretary of Health and Human Services in developing the annual update factor for hospital payments under the medicare program. The statutory language requires that hospital payments reflect amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

The Committee has, however, for the last two years overridden the Administration's recommended update factor. The Committee finds itself in the same situation once again this year as it finds the Secretary's recommended FY 1987 update factor unacceptable. The Committee concludes that the Administration, in developing the update factor for fiscal year 1987 used factors other than those originally anticipated in the legislation.

In response to concerns of the Secretarial use of the discretionary authority granted by Congress, the Committee has reluctantly taken the step of not only mandating the update factor for FY 1987 but also for FY 1988. The Committee requires that the Secretary, for the FY 1988 update factor, provide a report and a documented recommendation to Congress by April 1, 1987, on what the Secretary would recommend for the FY 1988 update factor. The Committee will review this report, along with the report of the Prospective Payment Assessment Commission, and make a determination as to what, if any, adjustments should be made to the FY 1988 update factor established under this legislation at market basket minus two percent.

The Committee anticipates that the Secretary will continue to publish the June 1 proposed regulation for FY 1988, providing for the market basket minus two percent update factor as well as recalibrating and making other adjustments as appropriate and

within the scope of the law. The final regulation would be published September 1, 1987, for implementation October 1, 1987.

The Committee believes that the most recent data available should be used in refining the market basket. The market basket is being established on a 1982 data source even though significant changes have taken place since then. Data from 1984 is available and should be used.

The Secretary of HHS would be required to recalibrate the diagnosis related group (DRG) weights annually to ensure that the DRG weights reflect the use of new technologies and other practice pattern changes affecting the relative use of hospital resources among DRG categories.

The Committee is most concerned that the Administration has failed to respond to Congress on the many studies and requests that would identify ways in which the PPS system could be refined to more accurately reflect the costs incurred per discharge. As the movement towards national rates progresses, the need for refinements to the system in order to provide for an equitable distribution of payments among hospitals becomes more urgent. The Committee understands that the Secretary of Health and Human Services has made the PPS studies and refinement issues the highest priority. The Committee further anticipates that work on refining the PPS system will enable consideration of legislation to make the system more equitable during 1987.

The Committee is concerned about the impact of the prospective payment system on rural hospitals. The Committee is also concerned about hospitals in rural areas which are on the margins of qualifying for the urban payment rate. The Committee believes that hospitals in counties that are in this category may be experiencing hardship under the PPS system and would urge that the Secretary examine what options are available to remedy this situation. Furthermore, the Committee is concerned about the impact of the outlier policy on rural hospitals as well as the accuracy of the methodology of establishing the rural/urban payment rates. The Committee will be examining more closely the issue of rural hospitals in the coming year.

Effective date.—The provisions would be effective for cost reporting periods beginning during fiscal years 1987 and 1988 for prospective payment system-exempt hospitals; and for discharges occurring during fiscal years 1987 and 1988 for prospective payment system hospitals.

3. Limitation on payments for capital-related costs for inpatient hospital services of DRG hospitals under medicare (Sec. 10203 of the bill)

Present law.—The Social Security Amendments of 1983, P.L. 98-21, implemented a prospective payment system for hospital inpatient operating costs. Under P.L. 98-21, capital-related costs are excluded from the prospective payment system until October 1, 1986. This exclusion was extended until October 1, 1987, by the Urgent Supplemental Appropriations Bill, P.L. 99-369.

If Congress does not enact legislation to include capital-related costs in the prospective payment system by October 1, 1987, medicare payment for such new costs would only be allowed if a State

has a capital-expenditure review agreement with the Secretary of HHS (under section 1122 of the Social Security Act) and the State had recommended approval of the expenditure.

The Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, provides that payment for return on equity capital will be separated from payments from other elements of capital-related costs and phased out over a three year period. For hospital cost reporting periods beginning in fiscal year 1987, payments for return on equity will be reduced to 75% of the otherwise allowable amount. For cost reporting periods during fiscal years 1988 and 1989, return on equity payments will be reduced to 50% and 25% respectively, of the otherwise allowable amounts.

Explanation of provision.—The bill would require the Secretary to ensure that the aggregate payment amount for capital-related costs associated with inpatient hospital services for hospitals under the prospective payment system (PPS) does not exceed the target limits as specified.

The Secretary of HHS would be required to estimate, based upon the best available data, the aggregate amount of payment for capital-related costs associated with inpatient hospital services for PPS hospitals and their exempt units for portions of cost reporting periods occurring in fiscal year 1986. The aggregate amount means the sum of such capital-related expenditures for hospitals under the prospective payment system.

This amount would establish the base on which payments in fiscal years 1987 through 1989 would be determined. The Secretary would be permitted to adjust the fiscal year 1986 base in each of the following fiscal years based on the most recent available data.

In determining the limit on payments in fiscal year 1987, the Secretary would be required to adjust the fiscal year 1986 base. The base would be reduced by an amount equal to 25 percent of the payment for return on equity. The Secretary would be required to ensure that the aggregate amount of such capital-related payments for portions of cost reporting periods occurring in fiscal year 1987 does not exceed 110% of the adjusted fiscal year 1986 base.

The fiscal year 1986 base used for determining the limit on payments in fiscal year 1988 would be reduced by the amount equal to 50% of the payment amount for return on equity. The Secretary would be required to ensure that the aggregate amount of such capital payments for portions of cost reporting periods occurring in fiscal year 1988 does not exceed 120% of the adjusted fiscal year 1986 base.

The fiscal year 1986 base used for determining the limit on payments in fiscal year 1989 would be reduced by an amount equal to 75% of the payment amount for return on equity. The Secretary would be required to ensure that the aggregate amount of such capital expenditures for portions of cost reporting periods in fiscal year 1989 does not exceed 130% of the adjusted fiscal year 1986 base.

If the Secretary determines that the aggregate amount of payment for capital-related costs would exceed the specified limits, the Secretary would be required to determine the necessary capital reduction percentage to ensure that payments do not exceed the specified limits. The Secretary would then reduce payments by the per-

centage necessary to provide that payments for portions of cost reporting periods in such fiscal years are within the specified limits. The Secretary would be required to determine such percentage based upon the best available data prior to the beginning of the fiscal year involved.

The percentage reduction determined by the Secretary to be necessary to ensure that payments do not exceed the target limits would not be subject to further adjustment in later fiscal years. There would be no judicial review of the percentage reduction factor. Final reconciliation of payments to hospitals would be made on the basis of such percentage.

The current law exclusion of capital-related costs from the prospective payment system until October 1, 1987, would not be changed.

The Secretary would be required to publish in the Federal Register the capital percentage reduction for each fiscal year as a part of the prospective payment regulations proposed in June. For fiscal year 1987, the Secretary would be required to publish the percentage reduction within 30 days after enactment, but no later than October 1, 1986.

The Prospective Payment Assessment Commission would be required to assess the assumptions used by the Secretary in determining the capital reduction percentage and report to Congress.

This provision would not apply to PPS-exempt hospitals or sole community providers.

For purposes of this provision, capital-related costs include those costs as prescribed by the Secretary in regulation. Return-on-equity would be phased out over three years as under present law.

Effective Date.—Enactment

4. Coverage of hospitals in Puerto Rico under DRG Prospective Payment System (sec. 10204 of the bill)

Present law.—Under current law, hospitals located in Puerto Rico are excluded from the prospective payment system and continue to be reimbursed on the basis of reasonable costs.

The Secretary of HHS was required to submit legislative recommendations to Congress with respect to methods for including hospitals located outside of the 50 States (including Puerto Rico) under a prospective payment system. The report was due April 1, 1984, and has not yet been received.

Explanation of provision.—The bill would require the Secretary to include hospitals located in Puerto Rico into a prospective payment system. The prospective payment rate for such hospitals would be equal to 75 percent of the Puerto Rico standardized rate and 25 percent of the national standardized rate.

The national standardized amount for Puerto Rican hospitals would be an equal blend of the rural and urban standardized amounts.

The Secretary would be required to determine a Puerto Rico standardized amount for urban and rural hospitals. The amount would be standardized by excluding an estimate of indirect medical education costs, adjusting for variations among hospitals by area wage levels and adjusting for variations in case mix among hospitals.

An area wage adjustment would be provided to hospitals located in Puerto Rico. Such adjustment would be based on the relative hospital wage level in the hospital's geographic area compared to the Puerto Rican average hospital wage level.

The Secretary would be required to estimate what additional payments will be made under the disproportionate share and outlier provisions and reduce the Puerto Rico average standardized amount to account for such payments.

The Secretary would be prohibited from restandardizing or otherwise adjusting the national standardized rate to reflect the inclusion of Puerto Rico into the prospective payment system.

The following provisions relating to hospitals under the prospective payment system generally, would also apply to hospitals located in Puerto Rico; outlier payments, payments for indirect medical education, payments relating to the cost of certified registered nurse anesthetists, payments relating to disproportionate share and other exceptions and adjustments as determined by the Secretary.

The current law provision under the prospective payment system relating to sole community providers or referral centers would not apply to hospitals located in Puerto Rico.

The Secretary would determine the Puerto Rico standardized rate for fiscal year 1987 by updating the target amount for fiscal year 1986 by the appropriate PPS update factor.

The Secretary would be required to issue regulations, no later than October 1, 1986 as are necessary to implement this provision.

The PPS update factor for hospitals located in Puerto Rico would be the same update factor as for other prospective payment hospitals beginning in fiscal year 1988.

Effective Date.—The provision would be effective with respect to cost reporting periods beginning on or after October 1, 1986.

5. Improving Quality of Care with Respect to Part A Services (sec. 10205 of the bill)

Present Law.—(a) *Refinement of the Prospective Payment System*—Under the medicare prospective payment system, hospitals are reimbursed on a per case (diagnosis related group—DRG) basis. Payment rates for each DRG reflect the average cost of providing care to patients classified in the DRG.

(b) *Requiring Notice of Patient Rights*—There is no statutory requirement that a statement of rights be distributed.

(c) *Discharge Planning*—By regulation, hospitals participating in medicare must have a discharge planning program to facilitate the provision of followup care.

(d) *Review of Conditions of Participation*—For a hospital to be eligible for medicare reimbursement, the hospital must be in compliance with medicare's conditions of participation for hospitals as set forth in subchapter B of title 42 the Code of Federal Regulations or must be accredited by a national accreditation body, such as the Joint Commission on Accreditation of Hospitals.

(e) *Study of Payment of Administratively Necessary Days*—Under prospective payment, payment for hospitals is made on a per case basis. No special provision is made for payment of administratively necessary days (ANDs). An AND is a day of continued

inpatient hospital stay necessitated by delays in obtaining placement of a patient in a skilled nursing facility (SNF).

(f) Continuation of Favorable Presumption of Waiver of Liability—Under the waiver of liability, payment may be made for services which are not covered because they were not medically necessary or were for custodial care if neither the beneficiary nor the provider knew or could reasonably have been expected to know that the services were not covered for these reasons. By regulation, a home health agency is presumed to meet this test if its denial rate on claims for services is 2.5 percent or less. A SNF is presumed to meet the test if its denial rate is 5.0 percent or less. Hospice providers are not eligible for a favorable presumption.

In a notice dated February 21, 1986, the Secretary issued regulations that eliminated the favorable presumption of the waiver of liability. Payment for noncovered services would have continued on a case-by-case basis. Implementation of the regulation was temporarily blocked by P.L. 99-272. As a result of the law, the favorable presumption will be continued until October 1, 1988, for SNF services. The favorable presumption for home health services will be continued until 12 months after the date on which ten regional intermediaries commence operation as required under Section 1816(e)(4) of the Social Security Act.

(g) Waiver of Liability for Technical Denials for Home Health Services—Beneficiaries who are confined to home and require skilled nursing care on an intermittent basis are eligible for home health services. Intermittent care generally is defined as permitting daily skilled nursing visits of up to eight hours a day for up to two to three weeks. Denials based on homebound and intermittent care requirements are commonly referred to as "technical denials." Under the waiver of liability, payment may be made for services excluded from coverage under Section 1862(a)(1) or (9) of the Social Security Act as unnecessary or as related to custodial care if the provider did not know and could not be expected to have known that payment would be denied for these reasons. The waiver of liability does not apply to technical denials.

(h) Development of Uniform Needs Assessment—Current law contains no provision.

(i) Expedited Review by Fiscal Intermediaries—Claims for hospice, home health, and SNF services generally are reviewed on a retrospective basis after the services are provided. Current law does not provide effective standards for timeliness in claims submission and review.

(j) Including Information in PPS Annual Reports—The Secretary is required to submit annual reports to Congress concerning the prospective payment system.

(k) Prior Authorization Demonstration Project—Medicare fiscal intermediaries have responsibility for deciding whether payment will be made for services provided by home health agencies and SNFs. Generally, these payment decisions are made on a retrospective basis after services are provided.

Explanation of Provision.—(a) Refinement of the Prospective Payment System—A number of studies have shown that, because of technical limitations with the DRGs, costs are substantially higher than the DRG payment for some patients. In other cases,

costs are substantially less. As a result of these limitations, hospitals which provide care to a more severely ill patient population may receive insufficient reimbursement. Even if total payments to a hospital during a year approximate costs of providing necessary care, hospitals may have incentives to inappropriately reduce services in an attempt to increase net revenues if payments and costs diverge substantially in individual cases. For these reasons, the Committee believes that there is a need to improve the case mix measurement system used in determining prospective payments for hospitals.

The Secretary would be required to submit a legislative proposal to improve the prospective payment system. The proposal should assure that per case payments approximate the cost of providing medically necessary care in an efficient manner for individual patients or classes of patients with similar conditions. The proposal should account for variations in severity of illness and case complexity which are not adequately accounted for by the DRGs; however, use of a severity of illness index is not specifically required. The report is due no later than 2 years after enactment.

(b) **Requiring Notice of Patient Rights**—The medicare provider agreement with hospitals would be amended to require that hospitals provide a notice of patient rights to beneficiaries at the time of hospital admission. The notice would include information concerning: (i) rights to inpatient and post-hospital care under medicare; (ii) financial liability for continued inpatient stay if a hospital serves notice that further inpatient care is no longer necessary; (iii) rights to appeal such a notice; (iv) financial liability for continued stay if the appeal is unsuccessful; and (v) other such information as the Secretary of Health and Human Services deems appropriate. It is the Committee's intent that the statement of rights be written in terms easily understood by the elderly. The Committee also intends that the statement of rights be provided in translation to non-English speaking beneficiaries.

(c) **Discharge Planning**—The Committee believes that sound discharge planning is essential to ensuring a safe transition after discharge from an acute care setting. The need for effective discharge planning has increased because the average length of hospital stay for beneficiaries has shortened significantly partly as a result of the prospective payment system and other changes in the health care system. Accordingly, the Committee has adopted a provision that would establish a set of minimum standards for discharge planning that must be satisfied for a hospital to participate in medicare.

Under the provision, hospitals would be required to provide a discharge planning evaluation for beneficiaries who are hospital inpatients: (i) upon request of the patient or attending physician; and (ii) for other patients likely to suffer adverse health consequences after discharge in the absence of discharge planning. The required evaluation would include an assessment of the patient's need for post-hospital services and the availability of those services. The conclusions of the discharge planning evaluation would be made available to the patient and the attending physician to assist in the development of a final discharge plan. Discharge planning would be performed by, or under the supervision of, a registered nurse,

social worker, or other appropriately qualified personnel. The requirements could not be satisfied by accreditation by a national accreditation body acting pursuant to Section 1865(b) of the Social Security Act unless the Secretary determines the discharge planning requirements of the accreditation body are at least as rigorous as those required by this provision.

(d) Review of Conditions of Participation—The Secretary would be required to arrange for a study of the standards used to qualify hospitals for participation in medicare. The purpose of the study would be to determine whether the standards are adequate to ensure quality of care. Enactment of the prospective payment system in 1983 has changed financial incentives for hospitals in a fundamental way. While the overall effect of the new incentives has been positive, there exists a possibility that hospitals might inappropriately reduce essential services to increase net revenues. The Committee believes that rigorous and detailed quality assurance standards are essential to safeguard against this possibility. Accordingly, the Committee believes that a review of the standards used to qualify hospitals for participation in medicare is appropriate at this time.

The Committee recognizes that the Secretary recently completed a review of medicare's conditions of participation for hospitals and issued final regulations changing these conditions in June of this year. This review was initiated by the Secretary in 1980 before enactment of the prospective payment system, and the purpose of the review was to simplify the conditions of participation to provide maximum flexibility for providers. Because the review was not focused on the possible need to strengthen quality assurance mechanisms to serve as a counterbalance to the incentives inherent in prospective payment, the Committee believes that the recently completed review is not sufficient to satisfy the Committee's concerns.

The Committee intends that the study encompass both medicare's conditions of participation for hospitals as set forth at 42 C.F.R. subchapter B and the standards used by national accreditation bodies recognized by the Secretary, such as the Joint Commission on Accreditation (JCAH) and the American Osteopathic Association (AOA). The Committee notes that about 5,000 hospitals are qualified to participate in medicare by virtue of accreditation by the JCAH or AOA. These hospitals are not directly subject to the conditions of participation that appear in regulation. Only about 1,000 hospitals are directly subject to the regulatory conditions of participation. Thus, there is a clear need to review both the regulatory standards and standards established by national accreditation bodies. It is the Committee's intent that the Secretary consult with a wide variety of experts in quality assurance and with representatives of providers, physicians, and consumers in conducting the study. The study would be due within 2 years after enactment.

(e) Study of Payment of Administratively Necessary Days—Under the prospective payment system, hospitals receive a fixed per case payment irrespective of actual length of stay. A hospital which is unable to discharge a beneficiary because of difficulties in obtaining placement for the beneficiary in a SNF may be reimbursed less than costs if substantial delays in discharge result. Al-

though payment for these administratively necessary days has been included in the prospective payment system rates, these payments may be insufficient in some situations. Accordingly, it has been suggested that a separate payment be made for administratively necessary days (ANDs), that is, for additional days of inpatient hospital care necessitated by delays in obtaining SNF placement. Because of the complexity of the issues involved in implementing an AND payment system, the Committee believes that the advisability of making payments for ANDs should be carefully studied.

Under the provision adopted by the Committee, the Secretary would be required to conduct a study to determine whether payment should be made for ANDs. Such a payment would be separate from the per discharge and outlier payments made under prospective payment. The Secretary would be required to consider whether payment for ANDs is needed to minimize the potential for a disproportionate financial impact of prospective payment on hospitals located in areas where there is a shortage of nursing home beds. The Secretary would also be required to consider the potential for inappropriate payments for ANDs and the practicality and effectiveness of administrative mechanisms that could be used to prevent inappropriate payments. The report would be due by January 1, 1988.

(f) Continuation of Favorable Presumption of the Waiver of Liability—The Committee believes that it is appropriate to extend certain rules related to the waiver of liability for home health and SNF services by an additional year, to October 1, 1989. During the interval, the Secretary would be required to conduct a demonstration of a prior authorization system for home health and SNF services. After completion of the demonstration project, the Committee believes that it may be appropriate to consider either a further extension of current policy concerning the waiver or replacement of the waiver (in whole or in part) by a prior authorization system.

Under the proposal, a favorable presumption regarding the waiver of liability would be available to qualified hospice, home health, and SNF providers until October 1, 1989. Hospice providers having 2.5% or fewer claims denied on the basis of Section 1862(a) (1) or (9) of the Social Security Act would qualify. Current standards for home health and SNF providers would continue to apply.

(g) Waiver of Liability for Technical Denials for Home Health Services—The Committee notes that there is a considerable degree of uncertainty concerning standards for application of the homebound and intermittent care requirements for home health services. As a result of this uncertainty, a home health agency, acting in good faith and believing that the beneficiary satisfies the applicable standards, may provide costly services to a beneficiary only to find that payment has been denied after the fact.

To protect providers acting in good faith and to improve access to needed home health services, the Committee would extend the waiver of liability to allow for payment of home health services if the provider did not know and could not have been expected to know that payment would be denied based on a determination that the individuals was not homebound or did not require skilled nursing care on an intermittent basis. A home health agency would be

presumed to be without knowledge regarding these facts if no more than 2.5 percent of the claims submitted by the agency during the previous quarter were denied on the basis of homebound or intermittent care requirements. The favorable presumption provision would expire on October 1, 1989.

(h) **Development of Uniform Needs Assessment Instrument**—The Secretary of Health and Human Services would be required to develop a uniform needs assessment instrument to be used by discharge planners, providers, and fiscal intermediaries in evaluating an individual's need for hospice, home health, and skilled nursing facility (SNF) services, and other long-term care services of health-related or supportive nature. An advisory panel would be established for consultation with the Secretary. The Secretary would be required to submit a report to Congress concerning the needs assessment instrument no later than 1 year after enactment. The report would include an evaluation of the instrument and the advantages and disadvantages of using the instrument for determining whether payment should be made for hospice, home health, and SNF services provided to beneficiaries.

(i) **Expedited Review by Fiscal Intermediaries**—Reimbursement determinations for hospice, home health, SNF services are made by fiscal intermediaries on a retrospective basis after services have been provided. Because these services generally are provided on an ongoing basis, delays in claims processing can lead to substantial financial burdens for providers if payment is denied. Current law does not establish effective standards for timeliness of claims review. In some situations, there can be a delay of up to 3 months or more between initial provision of services and first notification of the provider by the fiscal intermediary concerning coverage and reimbursement.

The Committee believes that this delay creates an unacceptable burden on hospice, home health, and SNF providers. Accordingly, under the provision adopted by the Committee, the Secretary would be required to develop procedures to expedite the claims review process for hospice, home health, and SNF services to minimize the delay between initiation of services and first notice from the intermediary to the provider as to whether payment will be made.

(j) **Including Information in PPS Annual Reports**—The annual reports to Congress would be expanded to include: (i) an evaluation of the adequacy of procedures for assuring the quality of post-hospital services provided under medicare; (ii) an assessment of problems that have prevented beneficiaries from receiving appropriate post-hospital services; and (iii) information concerning reconsiderations and appeals for post-hospital services covered under medicare.

(k) **Prior Authorization Demonstration Project**—The Secretary would be required to conduct a series of demonstration projects related to prior authorization of home health and SNF services. The purpose of the demonstration would be to demonstrate the feasibility of a prior authorization system and to evaluate prior authorization as an alternative to the current system of retrospective review.

Effective Date.—Paragraphs (a), (d), (e), (h), (j), and (k) would be effective on enactment. Paragraph (b) would be effective no later

than eight months after enactment. Paragraph (c) would apply to hospital provider agreements no later than 1 year after enactment. Paragraphs (f) and (g) have varying effective dates. Paragraph (i) would be effective one year after enactment.

6. Off-budget treatment of federal hospital insurance trust fund in fiscal year 1987 (sec. 10206 of the bill)

Present Law.—Under current law the Federal Hospital Insurance Trust Fund (HI) receipts and disbursements are included in the unified budget until fiscal year 1993. In 1993 the HI Trust Fund will be removed from the unified budget. Under the Balanced Budget and Emergency Deficit Control Act of 1985, the Old-Age and Survivors and Disability Insurance Trust Funds (OASDI) were removed from the unified budget for fiscal year 1986 and beyond. However, the disbursements and expenditures of these two trust funds are included for purposes of determining whether the deficit exceeds the “maximum deficit amount” targets set in law.

Explanation of provision.—The Committee is concerned that as a result of the Balanced Budget and Emergency Deficit Control Act of 1985 the Hospital Insurance Trust Fund is treated differently for budget purposes than the Old-Age and Survivors and Disability Insurance Trust Fund. To preserve the historic relationship of the three trust funds for budget purposes, the bill would accelerate from fiscal year 1993 to fiscal year 1987 the effective date of the provision of the Social Security Act that removes the receipts and disbursements of the Federal Hospital Insurance Trust Fund (HI) from the unified budget presented by the President and considered by the Congress. The Committee bill would provide for the HI and OASDI trust funds to be treated the same under the Balanced Budget and Emergency Deficit Control Act of 1985. The disbursements and expenditures of all three trust funds would be included for purposes of determining whether the deficit exceeds the “maximum deficit amount” targets set in law.

Effective date.—The provision is effective beginning October 1, 1986.

7. Technical amendments and miscellaneous provisions relating to part A (Sec. 10207 of the bill)

Present Law.—(a) One year extension of pass-through for costs of certified registered nurse anesthetists—Under current law the costs of certified registered nurse anesthetists are passed through on a cost basis for PPS hospitals until October 1, 1987.

(b) Four-year designation period for rural referral centers—Under current law a rural hospital will be considered a rural referral center if it has at least 500 beds and meets other requirements. Under regulations, once a rural referral center has achieved referral status, it will be paid at the applicable urban rate for a three year period.

(c) Temporary waiver of inpatient limitations for Connecticut Hospice, Inc.—Current law requires that medicare-certified hospices maintain no more than 20% of total days as inpatient days. Connecticut Hospice, Inc. currently has waivers of virtually all the medicare requirements but the waivers expire on October 1, 1986.

(d) Massachusetts medicare repayment—Massachusetts operated a State-wide hospital demonstration project from October 1, 1982 through June 30, 1986. The effectiveness of the state system is judged by the Secretary to ensure that medicare expenditures under the demonstration are not greater than they would have been under medicare regular reimbursement rules. The Secretary of HHS has determined, based upon unaudited data, that medicare overpayments were made during the first two years of the Massachusetts waiver. As a result the Secretary has established a repayment schedule for the "overpayments".

(e) Technical and other miscellaneous provisions—Current law contains a number of technical errors.

Explanation of Provision.—(a) One-year extension of pass-through for costs of certified registered nurse anesthetists—The bill would extend by one year the pass-through for costs of certified registered nurse anesthetists.

(b) Four-year designation period for rural referral centers—Hospitals currently with rural referral status under the PPS system would receive payment at the urban rate for a four year period rather than for a three year period. After the fourth year, each such hospital would be required to demonstrate that it continues to meet the criteria established by the Secretary. The Secretary would be prevented from terminating such classification before the end of the hospital's fourth cost reporting period.

(c) Temporary waiver of inpatient limitations for the Connecticut Hospice, Inc.—Connecticut Hospice, Inc. would receive a waiver of the inpatient day requirement for a two year period provided that the proportion of inpatient days does not exceed 50%. The waiver would not be extended beyond this period.

(d) Massachusetts Medicare Repayment—The bill would prevent the Secretary from further recouping or otherwise reducing payments for these hospitals until January 1, 1988. The bill would not change any payment amounts that may become due.

(e) Technical and other miscellaneous amendments—(1) Correct and clarify section regarding payments under the indirect teaching adjustment;

(2) Correct and clarify section regarding payments under the disproportionate share provision;

(3) Clarify that all hospitals which have a medicare provider agreement would have to abide by the emergency care requirements;

(4) Allow SNFs to make election to be paid on a prospective payment basis based on their cost reporting periods rather than on a Federal fiscal year basis;

(5) Clarify that the Medicare (HI) tax on state and local government does not apply to certain campaign workers; and

(6) Make other miscellaneous corrections to COBRA and related laws.

Effective Date.—

(a) October 1, 1987

(b) Enactment

(c) Enactment

(d) Enactment

(e) The provisions would be effective as if they had been included in the enactment of the laws they amend.

Part 2—Provisions Relating to Parts A and B

1. *Elimination of periodic interim payment system (PIP) for DRG hospitals and prompt payment for medicare providers (sec 10221 of the bill)*

Present law.—(a) Periodic interim payment system—There are no current law requirements concerning periodic interim payments to providers. By regulation, the Health Care Financing Administration (HCFA) allows providers (hospitals, skilled nursing facilities, home health agencies and hospices) that elect such payments and which meet specified guidelines, the option of receiving periodic interim payments (PIP) every two weeks. The payments are based on an estimate of how much the medicare program owes the provider. Overpayments/underpayments are settled quarterly. HCFA has proposed eliminating PIP as an option for all hospitals, skilled nursing facilities, hospices and home health agencies effective July 1, 1987.

(b) Prompt payment for medicare providers—There are no current law requirements concerning prompt payment of claims. Historically, medicare has processed both part A and part B claims in a timely manner. HCFA has recently slowed down the average processing time for part A claims from an average of 9 days in the beginning of FY 1985 to an anticipated 27 days at the end of FY 1986; and for part B claims from 11 days in the beginning of FY 1985 to an anticipated 27 days at the end of FY 1986.

Explanation of provision.—(a) Periodic interim payment system—The periodic interim payment option would be eliminated for inpatient hospital services provided in PPS hospitals and exempt units of PPS hospitals, except for services provided in “disproportionate share” hospitals, sole community hospitals, and hospitals in States holding waivers under Section 1886(c) or Section 1814(b)(3). Cost-based providers could continue to receive PIP payments, at their election as under current regulations.

The Committee understands that the Administration believes that regular periodic interim payments to providers are inconsistent with the prospective payment system. While reimbursement on a cost-basis requires that approximations of medicare payments be calculated pending the completion of each cost-accounting year, the prospective payment system is not dependent on this reporting method.

However, because the Committee recognizes that elimination of periodic interim payments may present serious financial difficulties for certain hospitals, the Secretary would be required to permit payment on a periodic interim basis to hospitals to which the above exception applies, using a mechanism that is comparable to that which is currently in place under 42 CFR 405.454(j). In addition, the Secretary would be required to make available accelerated payments to hospitals if the hospital can demonstrate that it is experiencing significant cash flow difficulties resulting from the operations of the fiscal intermediary or unusual circumstances of the hospital operations.

(b) Prompt payment for medicare providers—Prompt payment of medicare claims would be required. “Clean” claims (i.e., claims which are free of any defect or impropriety, including the lack of any required substantiating documentation, such as incomplete or erroneous entries, and do not require special treatment, such as medical review, preventing timely payment) submitted for payment of services covered under medicare part A would be required to be paid within 22 calendar days of receipt by the medicare intermediary. If the claim is not “clean” and for that reason cannot be paid within the required time period, a notice would have to be sent to the provider who submitted the claim to inform them of expected delays.

“Clean” claims (meeting the definition described in the preceding paragraph) submitted for payment for services covered under medicare part B and provided by nonparticipating physicians and suppliers would be required to be paid within 22 calendar days of receipt by the medicare carrier. “Clean” claims submitted by participating physicians and suppliers would be required to be paid within 11 days of receipt by the medicare carrier. If the claim is not “clean” and for that reason cannot be paid within the required time period, a notice would have to be sent to the physician, supplier or beneficiary who submitted the claim to inform them of expected delays.

In the case of both part A and part B claims, if the claim is not paid and a notice is not mailed within the required time period, interest would begin to accrue (to the provider, physician, supplier or beneficiary) beginning on the day following the day payment or notice was due, and ending on the date on which payment is mailed or the date the notice is provided.

Interest payments would be made using funds otherwise available for federal administration of the medicare program, excluding those funds available for medicare contractor activities. In the Committee’s view, it should rarely, if ever, be necessary for interest payments to be made on medicare claims. However, because the Health Care Financing Administration has previously issued instructions to medicare intermediaries and carriers requiring that claims processing be intentionally delayed, the Committee believes that any necessary interest payments which result from a failure to comply with requirements of this provision should be paid by the agency responsible for the implementation of this statute.

Historically, timely payment of medicare claims has not been a significant issue. However, a virtual tripling of claims processing time within two years coupled with budgetary constraints has led to a significant cash flow problem for providers and medicare beneficiaries. The expansion of medical and utilization review activities has compounded the problem. While the Committee recognizes the value of and the need for medical and utilization review, it does not intend that such review activities lead to unreasonable delays in claims processing. Efforts should be made to alleviate the financial difficulties faced by providers of services where a significant portion of those services have been targeted for medical or utilization review.

The Committee has provided for payment of claims submitted by participating physicians and suppliers within 11 days with the

hope of providing an additional incentive for physicians and suppliers to participate in the medicare program. The Committee recognizes that payment delays by the medicare program can discourage participation, and would hope to strengthen the medicare participation program by adopting stricter payment standards.

Effective date.—The elimination of periodic interim payments to prospective payment system hospitals and their exempt-units would be effective with respect to discharges occurring on or after July 1, 1987. Prompt payment of part A claims would be effective for claims received on or after July 1, 1987. Prompt payment of part B claims would be effective for claims received on or after October 1, 1987.

2. Health Maintenance Organizations and Competitive Medical Plans (sec. 10222 of the bill)

Present Law.—(a) Repeal of “two for one” conversion requirement for certain health organizations (HMO’s) that had or have a medicare cost contract but which sign a medicare section 1876 risk contract must enroll two new medicare risk contract enrollees before they can convert one cost contract member. The purpose of the “two for one” conversion requirement was to limit the cost of the new risk contract provision.

(b) Require the provision of explanation of enrollee rights—There are no specific provisions to disclosure of benefits, services and patient rights to medicare beneficiaries enrolling in an HMO.

(c) Restricting waiver of requirement of 50 percent non-medicare enrollment—An HMO providing services to medicare enrollees under a section 1876 risk contract is required to maintain an enrollment consisting of no more than 50 percent medicare and medicaid beneficiaries. The Secretary of HHS has authority to waive the 50% non-medicare/medicaid enrollment standard of special circumstances warrant the waiver and if the HMO is making reasonable efforts to correct the deficiency.

(d) Requiring prompt payment of claims—There are no provisions concerning prompt payment of claims under current law.

(e) Requiring access to financial records and disclosures of internal loans—Section 1866(b) of the Social Security Act permits termination of a provider agreement where the Secretary has not been given access to certain information pertaining to persons or entities subcontracting with the provider. Under current law, there is no requirement of disclosure of “insider transactions” such as loans to related parties or organizations.

(f) Authority to impose civil money penalties—Section 1128A of the Social Security Act imposes civil money penalties on any person making certain improper claims with respect to the provision of medical items or services. The penalties include assessments up to \$2,000 per item or service and double the amount claimed in lieu of damages. Rights to notice, hearing and judicial review are set forth in the law.

(g) Study of AAPCC and ACR—HMO/CMP’s are reimbursed on a monthly basis on amount per enrolled beneficiary, based on the average cost of providing services to similarly situated beneficiaries in the fee-for-service sector. Reimbursement is in the amount of 95 percent of the adjusted average per capita cost (AAPCC). The

HMO/CMP is required to provide to the beneficiary a benefit package at least equivalent to the medicare benefit package. The HMO/CMP is required to develop an adjusted community rate (ACR) which reflects the HMO/CMP's standard charge for its non-medicare enrollees, adjusted to reflect the higher utilization and cost experience of the medicare population. If the AAPCC is in excess of the ACR, the HMO is required to return the difference to medicare or to develop a benefit package to provide additional services or reduced cost sharing.

(h) Allowing medicare beneficiaries to disenroll at a local Social Security Office—Under current law, enrollment and disenrollment procedures are administered by the HMO.

Explanation of provision.—(a) Repeal of “2 for 1” conversion requirement for certain health maintenance organizations. The bill would repeal the “two for one” requirement. The Committee believes that the “two for one” requirement adversely affects those medicare enrollees enrolled in an HMO who cannot convert to the risk contract because they cannot share in the additional benefits package provided to risk contract beneficiaries enrolled in the same HMO. Furthermore, in some cases it may be burdensome on HMO's by placing them in a less competitive situation.

(b) Requiring the provision of explanation of enrollee rights—All HMO/CMP's would be required to provide medicare beneficiaries an explanation of their rights as HMO enrollees, including but not limited to understandable descriptions of the benefits package, the meaning of any “lock-in” provisions, the scope of out-of-area coverage and emergency and urgently needed services and appeal rights. This information would be supplied to beneficiaries enrolled in risk contract HMO/CMP's in January 1987 and no less than annually thereafter.

(c) Restricting waiver of requirement of 50 percent non-medicare enrollment—No new waivers of current rule requiring that no more than 50 percent of enrollees be medicare or medicaid eligible would be granted other than for reasons of “disproportionate” representation of medicare and medicaid eligibles in the HMO/CMP service area. Where an existing waiver has been granted for reasons other than “disproportionate” representation, the Secretary must establish a schedule under which each waived HMO/CMP can meet the 50/50 requirement. Where a waiver has been granted for reasons other than for “disproportionate” representation, the waivers may only be extended if the Secretary determines that the organization (or its successor) has made and is continuing to make reasonable efforts to meet scheduled enrollment goals approved by the Secretary. The Secretary would be given authority to suspend further medicare enrollment if the waived HMO/CMP fails to meet its enrollment schedule (in order to come into compliance with the 50/50 rule). If the HMO/CMP does not have a 50/50 waiver, but is out of compliance with the 50/50 rule, the Secretary would be permitted to freeze new medicare enrollment.

(d) Requiring prompt payment of claims—the Committee believes that risk-basis HMO/CMP's should meet the same prompt payment standards for claims payment as will be applied to the rest of medicare (i.e. properly submitted claims must be paid within 22 days). Thus, consistent with other sections of this bill, risk-based HMO/

CMP's will be required to pay "clean" claims within 22 days, except where the HMO/CMP is under contract with the claimant. In instances where a contract exists between the HMO/CMP and the physician, hospital, or other claimant, the terms of the contract shall govern, and this provision shall not apply. Interest would be due on "clean" claims not paid on a timely basis. The Secretary would be given the authority, after notice and hearing, to provide direct payment to providers and suppliers in cases where the HMO/CMP has failed to meet its financial obligations and to make appropriate adjustments to the HMO's payment rate to reflect such payments.

(e) Requiring access to financial records and disclosure of internal loans—The amendment would require HMO/CMP's to provide the Secretary, upon request, access to books and records of certain subcontractors. In addition, HMO/CMP's would be required to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates and related parties.

(f) Authority to impose civil money penalties—Section 1128A would be amended to give the Secretary the authority to impose civil monetary penalties, not to exceed \$2,000 per violation, in cases where an entity providing items and services as an eligible organization under a section 1876 risk-sharing contract has failed substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under the risk-sharing contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals. The organization would be provided an opportunity to appeal a determination under the guidelines set forth in Section 1128A(b)(2).

(g) Study of AAPCC and ACR—The Secretary would be required to contract with an appropriate organization to study methods by which the adjusted average per capita cost (AAPCC) can be refined to more accurately reflect the average cost of providing care to different classes of patients (e.g. inclusion of variables such as activities of daily living, prior utilization history). The study would also include an assessment of mechanisms which could be developed to refine the Adjusted Community Rate (ACR). The Secretary would be required to submit legislative recommendations on methods by which the calculation of the AAPCC and the ACR may be refined by January 1, 1988.

(h) Allow Beneficiaries to Disenroll from an HMO at a local Social Security Office—The amendment would require the Secretary to expand disenrollment procedures to permit medicare beneficiaries to disenroll at their local Social Security office.

Effective date.—January 1, 1987.

3. Provisions relating to improvement of quality of care (sec. 10223 of the bill)

Present Law.—(a) Provider representation of beneficiaries on appeals and appeal of technical denials—If a beneficiary disagrees with a payment denial for services provided under medicare part A, he or she is entitled to appeal the determination. Since the inception of the medicare program, beneficiaries have been permitted

to be represented in their appeals by the provider who finished the services in question. In April, 1984, HCFA issued an intermediary manual instruction prohibiting such representation. HCFA also has prohibited appeals of "technical" denials, apparently based on the view that current law does not allow for appeals of these determinations. The denials which have been subject to restrictive rules involve homebound and intermittent care requirements for home health services.

(b) Prohibition of physician incentive plans—Incentive payments to physicians to reduce or limit services provided to beneficiaries are not prohibited under current law.

(c) Study to develop a strategy for quality review and assurance—There is no provision in current law.

Explanation of Provision.—(a) Provider representation of beneficiaries on appeals and appeal of technical denials—Providers would be allowed to represent beneficiaries on appeals. To avoid possible conflicts of interest, the provider would be prohibited from representing the beneficiary with respect to issues that concern the beneficiary's possible obligation to pay the provider for services not covered by medicare. Beneficiaries would have a right to appeal any payment denial for home health services, including denials based on homebound or intermittent care requirements.

(b) Prohibition of physician incentive plans—Incentive payments to a physician by a hospital, health maintenance organization (HMO), or competitive medical plan (CMP) as an inducement to reduce or limit services to beneficiaries under the care of the physician would be prohibited. The Committee believes that such incentive payments may create a conflict of interest that may limit the ability of the physician to exercise independent professional judgment in the best interest of his or her patients.

The Committee recognizes that incentive arrangements are necessary to the operation of some types of HMOs or CMPs. The Committee also recognizes that many of these arrangements pose no inherent threat to quality of care. In particular, many HMOs and CMPs have incentive plans which allow physicians to share in an overall operating surplus or in a favorable variance in the organization's overall financial plan in relation to forecast. Under this type of plan, there is no direct link between a physician's treatment decision and the amount of any bonus received. In contrast, under other arrangements, especially those that do not involve any risk-sharing among physicians, there may be a direct link between treatment decisions and bonus payments. Furthermore, the magnitude of the incentives provided may be so great as to threaten the ability of the physician to exercise independent professional judgment. Thus, the Committee believes that some incentive arrangements should be allowed while others should be prohibited.

Because of the wide variety and complexity of compensation arrangements offered by HMOs and CMPs, the Committee decided that a comprehensive study is needed before establishing exceptions to the general prohibition. Accordingly, the provision has a delayed effective date of January 1, 1988 as it applies to HMOs and CMPs. In addition, the provision requires the Secretary to submit a report to Congress by April 1, 1987 concerning appropriate exception to the prohibition for HMOs and CMPs.

The Committee notes that the prohibition only applies to physicians with direct patient care responsibilities. It is the Committee's intent that the prohibition not apply to hospital incentive arrangements with physicians who have a management or supervisory responsibility with respect to the operation of a hospital department (such as radiology or clinical laboratory services) insofar as the purpose of the arrangement is limited to encouraging efficiency in the operation of the department. The prohibition also would not apply to a physician who provides ancillary services under contract to a hospital.

Hospital, HMOs, and CMPs that knowingly violate the provision would be subject to civil monetary penalties of up to \$2,000 for each patient with respect to whom an incentive payment was made. Physicians who knowingly accept prohibited payments would be subject to penalties of up to \$2,000 for each patient.

(c) Study to develop a strategy for quality review and assurance—The Secretary would be required to contract with the Institute of Medicine to conduct a major study concerning quality of care. The study would consider a number of issues including the adequacy of current methods for measuring, reviewing, and assuring quality of care and the adequacy of methods available to correct identified quality of care problems. The study would be due 2 years after enactment.

Effective Date.—Paragraph (a) is effective on enactment. Paragraph (b) is effective 6 months after enactment as it pertains to incentive payments made by hospitals and on January 1, 1988 as it pertains to incentive payments made by HMOs and CMPs. Paragraph (c) is effective on enactment.

4. *Technical amendments and miscellaneous provisions relating to parts A and B (sec. 10224 of the bill)*

Present Law.—(a) Treatment of group purchasing agreements—Current law prohibits any person from receiving, giving, soliciting or offering any remuneration in return for referring or arranging for the furnishing of any item or service or in return for purchasing, leasing, or ordering any good, facility, or service for which payment can be made under medicare.

Hospitals and other providers have purchased medical supplies and equipment through their participation in group purchasing organizations (GPOs). GPOs purchase goods and services for participating institutions. A service or transactional fee is charged to participating institutions by GPOs. In some situations, these fees are paid by the vendor on behalf of the hospital or other provider.

This practice constitutes a technical violation of medicare anti-fraud and abuse provisions.

(b) Extension and clarification of competitive contracting authority—The Deficit Reduction Act of 1984 provided the Secretary with the authority to enter into two competitively bid contracts under part A and two such contracts under part B to replace poor performing contractors. This authority expires on September 30, 1986.

While the Secretary has used this authority to enter into competitively bid cost contracts, competitive bidding has not been used in the negotiation of fixed-price contracts.

(c) Consolidated Omnibus Budget Reconciliation Act technical corrections—Current law contains a number of technical errors.

Explanation of provision.—(a) Treatment of group purchasing agreements—The bill would legalize the payment of administrative fees to GPOs by vendors for goods and services that may be paid for by medicare but only where full disclosure of such payment is made.

(b) Extension and clarification of competitive contracting authority—The proposal would extend the Secretary's authority to enter into competitively bid contracts for three years and clarify language to include fixed-price contracting.

(c) Consolidated Omnibus Budget Reconciliation Act technical corrections—The bill would: (1) Clarify that a one-year transition period is provided for foreign medical graduates (FMGs) who have not passed the FMGEMS. From July 1, 1986 through June 30, 1987 such an FMG will be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted;

(2) Allow the Secretary to announce HMO/CMP rates by September 7 of each year rather than publish;

(3) Clarify effective date of the provision regarding penalties for billing for assistants at surgery for certain cataract operations;

(4) Allow temporary use of carrier prepayment screening as a substitute for preprocedure review;

(5) Clarify that the termination date of ACCESS demonstration project is July 31, 1987; and

(6) Correct other miscellaneous provisions.

Effective Date.—(a) The provision would apply to payments made before, on or after the date of enactment.

(b) The provision would be effective for contracts entered into on or after October 1, 1986.

(c) The provision would be effective as if it had been included in the enactment of the COBRA.

Part 3—Provisions Relating to Medicare Part B

1. *Extension of premium payment provision through 1989 (sec. 10231 of the bill)*

Present Law.—The Secretary is required to calculate and announce each September the amount of the monthly premium that will be charged in the following calendar year for individuals enrolled in the Supplemental Medical Insurance (part B) portion of medicare. The Secretary is required to calculate the premium amount so as to produce premium income equal to 25% of program costs for enrollees age 65 and over. The annual increase in the part B premium cannot exceed the rate of increase in the cost-of-living adjustment for the social security program. This provision has been in place since 1973.

Beginning in 1989, the premium calculation would revert to an earlier method under which the premium amount is the lower of: (1) an amount sufficient to cover one-half of program costs for the aged; or (2) the current premium amount increased by the percentage by which cash benefits were most recently increased under the

cost-of-living adjustment (COLA) provisions of the social security program.

Explanation of Provision.—The bill would extend the current law requirement whereby the portion of part B program costs financed by premium income equals 25% for one additional year, through CY 1989. If there is no social security cost-of-living adjustment, the monthly premium would not be increased that year.

Effective Date.—The provision would be effective on enactment.

2. Payment for physicians' services, restrictions on reasonable charge limitation and incentives for physician participation (sec. 10232 of the bill)

Present Law.—(a) Extend and modify limits on physician fee increases—Medicare pays for physicians' services on the basis of medicare-determined "reasonable charges", the lower of a physician's billed charge, the charge customarily made by the physician, or the prevailing charge limit. Customary and prevailing charges generally are updated annually.

Annual increases in prevailing charge levels are limited by the Medicare Economic Index (MEI) which reflects general inflation and changes in physicians' office practice costs. The prevailing charge for a service as used for payment purposes is the lower of the 75th percentile of customary charges for the service in the area, or the unadjusted prevailing charge in a base year increased by the MEI.

The Deficit Reduction Act of 1984 (P.L. 98-369) froze medicare payments for all physicians for the 15-month period beginning July 1, 1984, and established the participating physician program. Participating physicians were allowed to increase their actual charges. Nonparticipating physicians were prohibited from increasing their charges above April-June 1984 levels. A participating physician is a physician who agrees to accept medicare assignment on all services. Nonparticipating physicians are free to accept or refuse assignment on a claim-by-claim basis.

The freeze on payments was extended through April 30, 1986, by emergency legislation. Under the Consolidated Omnibus Budget Reconciliation Amendments (COBRA) of 1985 (P.L. 99-277), on May 1, 1986, participating physicians received a prevailing charge increase of 3.15% plus an additional 1% increase.

The freeze on actual, customary, and prevailing charges for nonparticipating physicians was extended through December 31, 1986. COBRA established one set of maximum allowable prevailing charges for participating physicians and another set for nonparticipating physicians. Under current law, participating and nonparticipating physicians will receive a customary prevailing charge update on January 1, 1987. Participating physicians would receive an estimated 3.2% prevailing charge increase based on the MEI for 1987; nonparticipating physicians would receive a 3.15% increase based on the MEI for 1986.

(b) Prohibit administration regulation on overpriced procedures and require study—In a Federal Register notice dated February 18, 1986, the Secretary announced a proposed rule that would authorize the Health Care Financing Administration to make payment reductions under part B on the basis of "inherent reasonableness."

Under this regulation "new reasonable charge limits" could be established when the standard methodology results in "unreasonably excessive charges."

(c) Programs to increase physician participation—Each year physicians are given the opportunity to sign participation agreements. Carriers are required to administer the annual participating physician enrollment process, but do not otherwise conduct programs to encourage participation or to provide information to beneficiaries about the program. The Secretary of Health and Human Services is required to publish directories listing the name, address, and specialty of participating physicians. Directories are available for use by the public at district and branch offices of the Social Security Administration, and directories are sent to each participating physician to facilitate referrals between participating physicians.

(d) Unnecessary services—Carriers and peer review organizations (PROs) review the medical necessity of physician services provided to beneficiaries. Unnecessary services are not covered and payment is denied. By accepting assignment, physicians agree not to bill the beneficiary even if medicare payment is denied. If assignment is not accepted, physicians may bill for services which have been found to be medically unnecessary, and the beneficiary may be required to pay the physician's full charge even though no medicare reimbursement is allowed.

(e) Disclosure requirement—If assignment is accepted, the beneficiary is not liable for charges in excess of the medicare approved charge. There is no requirement that a physician inform a beneficiary of the estimated amount of the extra charges if assignment is not accepted.

Explanation of Provision.—(a) Extend and modify limits on physician fee increases—On January 1, 1987, all physicians will receive an increase in prevailing charges based on percentage increase in the Medicare Economic Index (MEI) for services provided in 1987. The percentage increase in the MEI for 1987 is estimated to be 3.2%. The increase will apply to the maximum allowable prevailing charge levels for participating and nonparticipating physicians respectively as established by COBRA, and in effect during the 8-month period ending on December 31, 1986. In future years, the respective prevailing charge levels of participating and nonparticipating physicians will be increased by the percentage increase in the MEI applicable for services provided during the year. Participating physicians would receive an additional 1% bonus increase in their prevailing charges during 1987 and in each subsequent year. The bonus for a year will apply only to services provided during the year and will not apply in the calculation of payments for any subsequent year. In other words, the bonus will not be included in the prevailing charge profile and will not compound in future years.

Assuming a 3.2% MEI increase for 1987, a 3.0% increase for 1988, a 4% increase for 1989, for a \$1000 maximum allowable prevailing charge for a participating physician during the 8-month period ending December 31, 1986, the maximum allowable prevailing charges in future years would be: \$1042.00 in 1987 ($\1000×1.042), \$1073.28 in 1988 ($\$1000 \times 1.032 \times 1.04$), and \$1116.10 in 1989 ($\$1000 \times 1.032 \times 1.03 \times 1.05$). The maximum allowable prevailing charge for nonparticipating physicians in effect during the 8-month

period ending on December 31, 1986 would be increased by 3.2% in 1987, 3.0% in 1988, and 4.0% in 1989.

The freeze on actual charges of nonparticipating physicians would be replaced by a limit on the rate of increase of actual charges, effective January 1, 1987. On that date, nonparticipating physicians could increase their actual charges by the 1987 MEI plus an additional 1%. In subsequent years, nonparticipating physicians could increase their charges by the MEI for the year. The additional 1% increase allowed in 1987 would be included in the base and would compound in future years.

Assuming a 3.2% MEI increase for 1987, a 3.0% increase for 1988, a 4% increase for 1989, for a \$1000 actual charge for a nonparticipating physician during 1986, the physician could increase his actual charges in subsequent years to: \$1042.00 in 1987 ($\1000×1.042), \$1073.26 in 1988 ($\1042.00×1.03), and \$1116.19 in 1989 ($\1073.26×1.04).

A special limit on actual charges would apply to nonparticipating physicians without actual charge data for a procedure during the base period.

In this situation, nonparticipating physicians would be prohibited from charging more than the 50th percentile of customary charges (weighted by frequency) for the procedure as provided by nonparticipating physicians in the area during the 12-month period ending on June 30, 1986, increased by the percentage increase in the MEI since 1986.

Carriers would be required to provide available information concerning maximum allowed charges for nonparticipating physicians. Monitoring and enforcement procedures developed for the current freeze on actual charges would be continued. Nonparticipating physicians who knowingly and willfully bill more than the allowed amount would be subject to civil monetary penalties and/or exclusion from medicare.

The Secretary would be prohibited from adjusting the MEI on a retrospective basis by substituting a rental equivalence or rental substitution factor for the housing component of the consumer price index that had been used in determining the MEI prior to 1985. A retrospective adjustment of the MEI in this manner would have reduced the 1987 MEI by approximately 2 percentage points.

The Committee notes that the participating physician program is voluntary. The purposes of the program is to assist elderly who cannot afford to pay more than standard coinsurance and deductible payments. By selecting a participating physician, the beneficiary knows in advance that he or she will not be liable for any extra out-of-pocket costs. The Committee believes that elderly who cannot afford to pay extra should be provided an opportunity to select a physician who they know will always accept assignment. While the Committee is presently of the view that payment differentials are needed to encourage participation, the need for payment differentials may be reduced as the participation program becomes more fully established. In addition, the Committee believes that the need for payment differentials should be reconsidered in the context of forthcoming reforms in physician reimbursement.

(b) Prohibit administration regulation on overpriced procedures and require study—The Secretary and the Health Care Financing

Administration would be prohibited from lowering medicare payment using either the "inherent reasonableness authority" or the proposed "new reasonable charge limitations" for services covered under medicare part B.

The Committee believes that the Secretary does not have the legislative authority to impose across-the-board cuts in payments. As provided by law, payment rates would continue to be determined on the basis of actual, customary, and prevailing charges and in certain cases the lowest charge level.

The provision prohibits actions by the Secretary to require carriers to reduce payment for items or services provided under part B where the proposed reduction in payment is based on a conclusion by the Secretary that charges for particular items or services are excessive. As provided in the Consolidated Omnibus Reconciliation Act of 1985, carriers would be permitted to correct for grossly excessive or grossly deficient charges, provided that the reasonable charge that is established is realistic and equitable. This carrier authority is limited to eliminating specific charges that are grossly excessive or deficient in comparison with charges for the same or similar items or services charges by other similarly situated vendors or suppliers. Such adjustments would be required to be made for particular items and services by carriers pursuant to guidelines established by the Secretary in regulations published by the Secretary. The carriers may not use the "inherent reasonableness" authority to depart from the charge-based methodology mandated by law. The Committee intends simply to allow the carriers, in establishing the prevailing charge, to eliminate grossly deficient or grossly excessive charges for particular items and services; this authority may not be used to eliminate a significant proportion of charges which would, in effect, result in a substantial departure from the charge-based methodology mandated by law.

After consultation with the Physician Payment Review Commission, the Secretary would be required to submit a report to Congress concerning payment reductions for overpriced physician services. The report would list procedures determined to be overpriced and the recommended amount of payment reductions. The report would also describe proposals for implementing the payment reductions and measures to ensure that payment reductions do not result in increases in out-of-pocket costs for beneficiaries. The report would be due no later than April 1, 1987.

The provision is not intended to effect the validity or invalidity of the Secretary's regulation on inflation indexed charges for non-physician services issued on September 30, 1985.

The Committee believes that certain physician services may be "overpriced" and that payment for these services should be reduced. The Committee is aware of a proposal being developed by the Administration to reduce payment for cataract surgery with intraocular lens implantation. This proposal is based on a comparison of the amount of time required to perform cataract surgery with lens implantation to the amount of time required to perform the surgery without lens implantation. While the amount of the payment reduction that the Administration may propose may be reasonable, the Committee notes that the payment reductions likely to be proposed could result in an increase in extra charges

on unassigned claims of as much as \$500 per procedure. The Committee believes that such a result would be unacceptable. Accordingly, the Committee would prohibit payment reductions for "overpriced" procedures and require submission of recommendations by the Secretary concerning payment reductions and means to protect beneficiaries against increases in out-of-pocket costs.

(c) Programs to increase physician participation—during 1985, 31.4% of total charges for physicians' were made on an unassigned basis. The actual charge on unassigned claims were 26.9% higher than the medicare approved charge. Estimated beneficiary liability for extra charges on unassigned claims totalled \$3.6 billion. A significant number of beneficiaries incurred extra charges on unassigned claims totalling more than \$1,000 per beneficiary per year.

By selecting a participating physician, a beneficiary knows in advance that he/she will not be liable for any out-of-pocket costs other than standard coinsurance and deductible payments. Currently, about 28% of physicians participate.

To assist beneficiaries in selecting a participating physician and help them limit out-of-pocket costs, the Committee believes that a number of programs are warranted to strengthen the participating physician program.

A directory of participating physicians would be sent to each beneficiary at the beginning of each year starting in 1988. Directories would be organized to facilitate their use by beneficiaries. One or more directories would be used in each carrier service area as appropriate. Physicians would be listed by specialty and locality. The Committee believes that distribution of the directories is needed as a practical step to assist beneficiaries who wish to select a participating physician.

Carriers would be required to develop and implement programs to recruit and retain participating physicians. Recruitment programs would include: educational and outreach activities, seminars, and/or mail and telephone contracts, in addition to the basic annual mailing of participation letters. A professional relations staff for participating physicians would be required to handle billing and other problems related to payment of claims. Carriers would also be required to develop and implement programs to familiarize beneficiaries with the participating physician program and assist them in using the program to select physicians. The Secretary would be required to provide incentive payments to carriers that were successful in increasing the number of participating physicians. A bonus pool equal to 1% of total payments to carriers for claims processing would be available. Bonus payments would be made at the beginning of each year starting in 1988, based on the results of the participation enrollment process for the preceding year.

The medicare provider agreement for hospitals would be amended to require that hospitals make the participating physician directory available to beneficiaries. In addition, when referring a patient for further medical care on an outpatient basis, hospital personnel would be required to provide the name of at least one qualified participating physician of appropriate specialty if one is available.

(d) **Unnecessary Services**—The Committee believes that a consistent policy should apply with respect to liability for unnecessary services whether assignment is accepted or not. Under the provision adopted by the Committee, physicians who do not accept assignment on a claim would be prohibited from charging for unnecessary services. If payment has been made, the physician would be required to make a refund. A physician would be allowed to charge for an unnecessary service if: (i) the physician did not know and could not reasonably have been expected to know that the services would be determined to be unnecessary or (ii) the beneficiary was informed in advance that medicare coverage would be denied and agreed to pay for the service. Denial notices would be sent by the carrier (or the peer review organization) to both the physician and the beneficiary. Physicians would be required to refund payments within 30 days after receiving a denial notice unless the physician requests a reconsideration of appeal. The physician would be required to refund payment within 15 days after an adverse determination on reconsideration or appeal. A knowing and willful failure to make a refund on a timely basis would be subject to civil monetary penalties and/or exclusion from the medicare program.

(e) **Disclosure requirement**—The Committee believes that wherever practical, beneficiaries should be given information in advance concerning the amount of their potential liability for extra charges on unassigned claims. Without this information, beneficiaries cannot make informed decisions regarding source of care.

Under the provision adopted by the Committee, physicians providing elective surgical procedures on an unassigned basis would be required to provide fee information to the beneficiary in advance of performing the procedure. The physician would be required to provide a disclosure form that shows the physician's estimated actual charge for the procedure, the medicare approved charge, and the amount of any extra charges in excess of the medicare approved charge. The beneficiary would be required to sign the disclosure form, acknowledging receipt of this information. The requirement would only apply to elective surgical procedures as defined by the Secretary with an actual charge of \$500 or more. Physicians failing to provide the disclosure would be required to refund any payments received from the beneficiary in excess of the medicare approved charges. Knowing and willful violations would be subject to civil monetary penalties and/or exclusion from the medicare program.

The Secretary would be required to develop an effective method for monitoring compliance with the requirement. One approach would be to modify the claim form to include a statement to be initialed by the beneficiary indicating that the required information had been provided. Carriers could initiate an investigation if the payment forms do not have the required initialing in a substantial number of procedures provided by a physician. Alternatively, a special notice could be provided in the explanation of medical benefits if the required initialing did not appear on the claim.

Effective Date.—Paragraph (a) is effective on January 1, 1987, except that the prohibition concerning retrospective adjustment of the MEI is effective on enactment. Paragraph (b) is effective on enactment. Paragraphs (c), (d), and (e) are effective on October 1, 1987.

3. Payment rates for renal services and improvements in administration of end stage renal disease networks and program (sec. 10233 of the bill)

Present Law.—(a) Composite rates for dialysis treatment—End Stage Renal Disease (ESRD) facilities receive a “composite” payment rate for each dialysis treatment furnished. It is based on a weighted average of facility mix (hospital-based/free-standing) and a weighted average of in-facility and home dialysis. Free-standing facilities are currently paid on average \$127 per treatment and hospital-based facilities receive on average \$131 per treatment. Exceptions to the composite rate are provided if it is determined that a facility is an isolated essential facility. The Administration, in proposed regulations, is planning to reduce the composite payment rate for each treatment by approximately \$11.00 (9%).

(b) Payment for physicians’ services—Physicians are paid a monthly capitated payment for routine services provided to outpatient maintenance dialysis patients (ESRD). The rate of approximately \$187 per patient per month is based on an assumption that the physician provides one brief visit per dialysis session and one intermediate visit per month to the average ESRD patient. The fee is adjusted for the proportion of home and facility patients treated. The Administration has issued a final notice, effective August 1, 1986, to reduce the monthly capitated payment by approximately \$14 (8%).

(c) Reorganization of ESRD network areas and organizations—The Secretary is required to establish network organizations to assure effective and efficient administration of the ESRD program. The 32 network organizations are responsible for coordinating and evaluating ESRD services provided within assigned geographic areas. Under the Consolidated Omnibus Budget Reconciliation Act of 1986, the Secretary may consolidate the network areas to not less than fourteen. The Secretary is proposing through regulation to reduce the number of network to 14 and modifying the functions of the networks.

Explanation of Provision.—(a) Composite rates for dialysis treatment—The facility composite rate would be reduced by approximately \$5.50 per treatment (4.5%) based upon more recent cost audits, data on facility treatment mix, and home/in-facility dialysis mix. The base rate for free standing ESRD facilities could be no lower than \$117.50 and for hospital based facilities, \$121.50. This proposal overrides the Administration’s proposed rule published in the Federal Register on May 13, 1986.

The Committee is concerned about the appropriateness of the Administration’s proposed regulation to reduce the ESRD facility composite rate by approximately \$11.00 per treatment. As a result, the General Accounting Office (GAO) was asked to critique the Administration’s proposed reduction, considering the data and methodology used by HHS to compute the proposed rates. GAO responded in a report dated July 22, 1986, that the most recent data available to develop the proposed rates was used and used appropriately. GAO added that an exceptions process for facilities where the costs exceed the composite rate for reasons beyond their control would be appropriate.

Because of a concern that quality of care and access to care could be jeopardized by the \$11.00 reduction in the composite rate proposed by the Administration, the Committee bill provides only half of the rate reduction proposed by the Administration. Further, the Committee is concerned about access to quality care in rural and isolated areas. The Committee expects HCFA to improve the exceptions process for facilities with costs higher than those reflected in the composite rate. Specifically, HCFA should define the term "isolated essential facility" to reduce the data requirements so that more facilities deserving an exception to the composite rate will be able to successfully apply for such status.

The Committee bill provides for the appeals process to be streamlined so that an exception would be deemed to be approved unless the Secretary disapproved it by not later than 45 working days from the date the application was filed with the intermediary. The Committee intends that the fiscal intermediaries will complete within 15 working days their recommendations so that HHS will have 30 working days to make its decisions. If the isolated essential facility status is granted the facility would receive reimbursement based upon its request from the date it filed for the exception.

(b) Payments for physicians' services—The monthly capitated payment (MCP) rate for physicians treating ESRD patients would be reduced by approximately \$14 (8%) to reflect the shorter period of time spent on patients who receive their care at home. In 1983, the MCP rate was computed by HHS based on the average estimated physician involvement with ESRD patients, weighted by the national average percentage of patients who dialyze at home and at facilities. Generally, physicians have less involvement with home patients than with facility patients. GAO has determined that physicians could treat 3.9 home patients for every facility patient, a ratio of 3.9 to 1 rather than a 1.4 to 1 ratio used to establish the 1983 rates. The Committee bill provides for the Secretary of HHS to provide for an adjustment in the home/facility physician treatment ratio (used in establishing such payment rates) from 1.4 to 1 in order to reduce by approximately \$14 the average MCP rate for physician services to maintenance dialysis patients.

To better monitor the rate reductions, the Committee bill provides for the Secretary to contract with the National Academy of Science's Institute of Medicine to evaluate the effects of the proposed physician and facility rate reductions to determine if access to care or quality of care is being effected. A report to Congress on the results of the study is to be made by January 1, 1988. Once the study is completed it is the intent of the Committee to review the proposed rates.

(c) Reorganization of ESRD network areas and organizations—The Committee bill provides for a network program with a funding source that would better meet the needs of medicare ESRD beneficiaries. The bill would override the proposed rule published in the Federal Register on April 15, 1986.

The Secretary is directed to establish at least 17 ESRD networks. The Secretary is to publish in the Federal Register, after consultation with appropriate professional and patient organizations, the criteria for determining the geographic area for each network. In order to better evaluate the performance of networks in the future

and to establish the reorganized networks, the Secretary is directed to establish standards, criteria and procedures for evaluating networks. The Committee intends that HHS will designate existing networks or a combination of existing networks in first establishing the new network organizations. The Committee hopes that existing networks will voluntarily combine and request being designated as the network in their geographic area. Once a network administrative organization agreement has been established it may not be terminated by the Secretary unless it fails to meet the established standards and criteria. At least one patient representative is to serve on each network council and medical review board.

The responsibilities of the networks are to include: (1) collecting, validating and evaluating patient and facility data, (2) developing quality assurance standards, (3) conducting reviews and evaluations of the delivery of ESRD services, (4) conducting on-site review of the medical care provided beneficiaries in facilities when it is deemed necessary by a medical review board or the Secretary, (5) providing recommendations to ESRD facilities for improvements in ESRD care, (6) implementing a procedure for evaluating and resolving patient grievances, and (7) working with patients and facilities in encouraging participation in vocational rehabilitation programs.

In order for the networks to perform the functions required and to place the networks on a sound financial basis the Secretary would be required to reduce the amount of each composite rate payment for each treatment by 50 cents and provide for payment of such amounts to each network. Traditionally, home dialysis treatments are provided three times a week, thus \$1.50 per week would be transferred to the area network. The Committee understands that some existing and emerging technologies may require the equivalent of more or less than three dialyses per week. It is the intent of this legislation that an ESRD patient be considered to have three dialyses per week and that \$1.50 per week be transferred to the area network. Each network would receive the total amount withheld from facilities in that network's geographic area. If the new networks are not operational by January 1, 1987, it is the intent of the Committee that the Secretary is to fully fund the existing networks from this source of revenue.

The Secretary would be required to establish a national end stage renal disease registry from data reported by ESRD network organizations, transplant centers and other sources. This data should cover on all ESRD patients to assist the Congress and the medical community in dealing with ESRD related issues. The Secretary is to coordinate data collection activities and determine the appropriate location of the registry. A report on the progress made in establishing the registry is due by January 1, 1987, and the registry is to be established by January 1, 1988.

Because of the controversy over the safety of reusing dialyzer filters, the Secretary would be required to establish by no later than January 1, 1988, protocols on standards and conditions for the reuse of dialyzer filters for those facilities and providers which reuse such filters. The Secretary is also directed to report by January 1, 1988, on the results of a study of the appropriateness of establishing protocols on standards and conditions for the reuse

where appropriate of other dialysis supplies. The Secretary would be required to incorporate protocols established by this bill into the facilities; conditions of participation. Failure of a facility to follow an established protocol would subject the facility to denial of participation in the medicare program and to denial of payment for dialysis treatment.

Effective date.—The amendment applies to facility rates as of October 1, 1986, for physician rates August 1, 1986, for network organizations January 1, 1987.

4. Technical amendments and miscellaneous provisions related to part B (sec. 10234 of the bill)

Present Law.—(a) Additional members for Physician Payment Review Commission—The Physician Payment Review Commission as established by P.L. 99-272 consists of 11 commissioners. The purpose of the Commission is to provide recommendations concerning physician reimbursement under medicare part B.

(b) Effective date of voluntary disenrollment from medicare—Under current law, a beneficiary's coverage period under part B of medicare can be terminated by: (1) filing a notice that he or she no longer wishes to participate in the program; or (2) nonpayment of premiums.

When a beneficiary files a notice to disenroll from part B, the effective date of the termination is the close of the calendar quarter following the calendar quarter in which the notice is filed; a termination for nonpayment of premiums takes effect with the end of a grace period (not more than 90 days).

(c) Report on technical issues related to prospective payment of hospital-based physicians—Current law contains no provision.

Explanation of Provision.—(a) Additional members for Physician Payment Review Commission—The Commission would be expanded by two members. It is the Committee's intent that at least one of the new Commissioners be a rural physician.

(b) Effective date of voluntary disenrollment from medicare—The effective date of termination when filing a notice would be the close of the calendar quarter in which the notice is filed.

(c) Report on technical issues related to prospective payment of hospital-based physicians—The Secretary would be required to study and submit a report to the Committee on Ways and Means concerning technical issues related to design and implementation of a prospective payment system for hospital-based physicians.

The report would address the following issues: (i) definition of the specific radiology, antesthesia, and pathology services that could be included in a prospective payment system, (ii) and need, if any, for a transition from hospital specific to national payment rates, (iii) methods available for adjusting payment rates to account for regional variations in practice costs or regional variation in general earnings levels, and (iv) other technical implementation problems. As part of the report, the Secretary would be required to develop a combined medicare part A and part B data file from the most recently available period for use in developing prospective payment rates for radiology, pathology, and anesthesia services (including services provided by certified registered nurse anesthetists) to beneficiaries who are hospital inpatients. The data file should consist of

at least a 5% nationwide sample of all inpatient hospital admissions for medicare beneficiaries during a 6 to 12 month period of time. The data file should accumulate reasonable charges and costs for the listed services on a per-case (DRG) basis. The report and associated data files would be due as a report to the Committee on Ways and Means no later than April 1, 1987.

Effective Date.—Paragraph (a) would be effective 60 days after enactment. Paragraph (b) would be effective to notices filed on or after October 1, 1986. Paragraph (c) is effective on enactment.

Part 4—Improved Review of Quality by Peer Review Organizations

1. *Improved Review of quality by Peer Review Organizations (sec. 10241 of the bill)*

Present Law.—(a) PRO Review of Hospital Denial Notices—By regulation, hospitals are authorized to make determinations that further inpatient care is no longer medically necessary. If the attending physician concurs with this determination, the hospital may serve the beneficiary with a discharge notice and may begin to charge for continued stay beginning with the third day after serving the notices. The beneficiary may appeal the discharge notice to a peer review organization (PRO). If the PRO reverses the hospital's determination, the hospital may not bill for continued inpatient stay. The PRO is required to decide the appeal within three working days after receipt of the appeal. Under current policy, a beneficiary may incur financial liability for several days of continued stay before receiving notice of the PROs decision in the event of an adverse decision.

(b) PRO Review of Inpatient Services and Early Readmissions—PROs review the necessity and quality of hospital services provided to beneficiaries. To initiate review process, PROs must receive data concerning the number and type of hospital discharges from hospitals in the PROs service area. This information is provided to the PROs by the medicare fiscal intermediaries. There is no statutory provision regarding timely provision of data to the PROs. Under PRO contracts for 1986–88, PROs will be required to review all readmissions to a hospital where the readmission occurs within 15 days after initial discharge.

(c) Requiring PRO Review of Quality of Care—PROs are required to review a sample of the professional activities of health care practitioners and providers for purposes of determining whether the services provided were medically necessary and met professionally recognized standards of care. Under a provision of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, PROs are required to review services provided by health maintenance organizations (HMOs) and competitive medical plans (CMPs) effective January 1, 1987. The COBRA provision does not specify a required level of effort for PRO review of HMO and CMP services.

(d) Requiring Consumer Representation on PRO Boards—Current law contains no provision.

(e) Improving PRO Responsiveness to Beneficiary Complaints—Current law does not require that PROs review beneficiary complaints concerning quality.

(f) **Sharing of Information by PROs**—PRO confidential information is subject to rigorous protection. State ombudsmen and State protection and advocacy officials and national accreditation bodies, such as the Joint Commission on Accreditation for Hospitals, are not entitled to share PRO confidential information.

(g) **PRO Funding**—The costs of PRO review of inpatient hospital services is considered to be a cost incurred by hospitals in providing services to beneficiaries. Hospitals are required to have contracts with PROs under which PROs receive reimbursement for review costs by means of a direct transfer of funds by the Secretary from the Federal Hospital Insurance Trust Fund. Under current law, the aggregate amount to be paid to all PROs during a year must be no less than the aggregate amount expended during fiscal 1986 on PRO reviews adjusted for inflation.

Explanation of Provision.—(a) **PRO Review of Hospital Denial Notices**—The law would be amended to establish a statutory right to appeal a hospital discharge notice to a PRO and to ensure that a beneficiary who makes an appeal is not liable for continued stay until after receiving notice of the PROs decision. The beneficiary would have until noon on the next working day after receiving a discharge notice to file an appeal. The hospital would be required to transmit a copy of the medical records to the PRO prior to the close of business on the next working day after the day the beneficiary receives the discharge notice. The PRO would have one full working day after receiving the appeal and the records to decide the appeal and provide notice of its decision. The hospital would be prohibited from charging the beneficiary receives notice of the PROs decision.

The provision as adopted by this Committee does not require PROs to decide beneficiary appeals during weekends. If the number of appeals under this provision increases substantially, the Committee believes that may be appropriate to reconsider the matter and require that PROs consider beneficiary appeals during weekends.

(b) **PRO Review of Inpatient Services and Early Readmissions**—The Secretary of Health and Human Services would be required to ensure that PROs receive each month, on a timely basis, either directly from hospitals or indirectly through fiscal intermediaries, hospital data needed to initiate required reviews of hospital care on a timely basis. PROs would be required to review at least a sample of readmissions occurring within 31 days after the date of the most recent discharge from the hospital. It is the Committee's understanding that a large percentage sample of readmissions would be reviewed during the first two weeks after initial discharge than during the subsequent two week period.

(c) **Requiring PRO Review of Quality of Care**—Each PRO would be required to devote proportion of its efforts to reviewing quality of care. Each PRO would also be required to provide a reasonable allocation of its quality of care review activities among the different settings in which services are provided to medicare beneficiaries. Factors to be considered in establishing a reasonable allocation of PRO review activities include the following—(i) whether there is reason to believe that there is a particular need for reviews of particular cases or settings because of previous problems

regarding quality of care; (ii) the cost of the reviews and the likely yield of reviews in terms of the number and seriousness of quality of care problems likely to be detected as a result of the review effort; and (iii) the availability and adequacy of alternative quality review and assurance mechanisms.

The Committee believes that it is important to remove any remaining uncertainty with respect to the requirement that PROs must review services provided by health maintenance organizations (HMOs) and competitive medical plans (CMPs). Under the provision approved by the Committee, PROs are required to initiate review of HMO and CMP services on January 1, 1987. The purpose of these reviews (which are to include both inpatient and outpatient services) is to determine whether the quality of care provided to beneficiaries meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings. By January 1, 1988, the level of effort of PRO review for beneficiaries enrolled in HMOs and CMPs must be equivalent on a per beneficiary basis to the level of effort of PRO review (including both quality and utilization reviews) of services provided to beneficiaries who are not enrolled in HMOs or CMPs.

The Committee recognizes that HMOs and CMPs provide health care services in a manner that is distinctive. Accordingly, PRO review of HMO and CMP services should take into account unique characteristics of HMOs and CMPs. To ensure that PRO protocols for review of HMO and CMP services are appropriate, it is the Committee's intent that the standards, criteria, and procedures used for PRO review of HMO and CMP services be developed with the advice and consultation of representatives of the HMO and CMP industry. Representatives of PROs should also be involved in this consultative process.

(d) Requiring Consumer Representation on PRO Boards—Each peer review organization (PRO) would be required to name at least one consumer representative to its board of directors.

(e) Improving PRO Responsiveness to Beneficiary Complaints—PROs would be required to conduct a review of all written complaints about the quality of medicare covered services if the complaint is filed by a beneficiary or a legally responsible person acting on behalf of the beneficiary. The extent of the required investigation is to be determined on a case-by-case basis by the PRO depending on the circumstances. The PRO would be required to inform the complainant of its conclusions regarding the complaint and disposition of the complaint. Before concluding that the services involved fail to meet professionally recognized standards of care, the PRO would be required to provide notice and an opportunity for discussion with the practitioner or provider involved in the complaint.

(f) Sharing of Information by PROs—National accreditation bodies, such as the JCAH, acting pursuant to Section 1865 of the Social Security Act and State agencies responsible for licensing or certification of providers and practitioners would have access to confidential PRO information upon request if the information: (i) relates to a specific case or possible pattern of substandard care; and (ii) is needed for the body or agency to carry out its official

function. State ombudsmen, and State protection and advocacy officials would have access to PRO confidential information upon request if the PRO determines that the information requested: (i) relates to quality of care; (ii) may reflect a failure in a substantial number of cases or a gross and flagrant failure in one or more instances to provide services of a quality which meets professionally recognized standards of care; and (iii) is needed by the body, ombudsman, or official to carrying out official duties.

(g) PRO Funding—The new PRO activities specified in this provision would be considered to be a cost incurred by providers (including HMOs and CMPs) providing covered services to beneficiaries and would be reimbursed in the aggregate by an amount not less than an amount determined by the Secretary to be sufficient to cover the costs of these activities. Funds identified under Section 1866(a)(1)(F) of the Social Security Act for PRO review of inpatient hospital services would continue to be used solely for the purpose inpatient hospital reviews by PROs and would not be used to cover the cost of the new PRO functions specified in this provision. Hospitals, SNFs, home health agencies, HMOs, and CMPs would be required to execute agreements with PROs regarding the review activities specified in this provision under which the activities would be considered to be a cost of providing services to be reimbursed by means of a direct transfer of funds from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund in appropriate amounts.

Effective Date.—Paragraph (a) would apply to hospital discharge notices served to beneficiaries starting with the first day of the first month that begins 30 days after enactment. The requirement under paragraph (b) concerning prompt submission of data would be effective no later than 6 months after enactment. The requirement under paragraph (b) concerning PRO review readmissions would be effective for PRO contracts entered into or renewed on or after January 1, 1987. The requirement under paragraph (c) concerning allocation of funds for PRO review is effective on January 1, 1987. The requirement of paragraph (c) concerning the level of effort of PRO review of HMOs and CMPs is effective on January 1, 1988. Paragraph (d) would apply to PRO contracts entered into or renewed on or after January 1, 1987. The requirement of paragraph (e) concerning review of beneficiary complaints amendment would apply to complaints received by PROs on or after the first day of the first month that begins 9 months after enactment. Paragraph (f) concerning PRO confidential information apply to requests for information received on or after the end of the first 6-month period after enactment. Paragraph (g) concerning PRO funding has an effective date of October 1, 1987 as it pertains to PRO review agreements with hospitals, SNFs, and health agencies and has an effective date of January 1, 1987 as it pertains to PRO review agreements with HMOs and CMPs.

Part 5—Assuring Access to Health Care

1. Incentives for the establishment of State health insurance pools (sec. 10251 of the bill)

Present law.—Under present law, states are not required to establish health insurance pools for the purpose of offering health insurance to people who are otherwise unable to purchase health insurance. Beginning in 1974 ten states have enacted laws establishing comprehensive health insurance pools. These states are: Rhode Island, Connecticut, Florida, Indiana, Minnesota, Montana, Nebraska, North Dakota, Wisconsin, and Tennessee. The state insurance pools are independent nonprofit corporations governed by a board and administered by an insurance carrier selected by the board.

Only health insurance carriers who provide health insurance plans which are governed by state law are required to participate in the pools. Because ERISA preempts state law, employer-based, self-funded health plans have been exempt from any state mandate.

Explanation of provision.—The Committee bill provides for each state to establish an insurance pool for people who do not have access to employment-based health insurance. Policies offered by the pools would have to be available to anyone in the state, except for individuals eligible for part A of medicare, regardless of health status.

Once the state establishes a health insurance pool, any employer, with 20 or more employees, doing business in the state would be required to participate in the insurance pool. If the employer did not participate in the pool, a tax equal to 5% of gross wages (as defined in the Internal Revenue Code Sec. 3401) paid or incurred during the taxable year would be imposed. If a state does not create a pool, there would be no tax on employers.

The insurance policies offered under the state pool would be designed to offer coverage typical of large employer plans. A premium could be charged based upon the reasonable actuarial determination of anticipated experience and expected expenses. The premium rate would be expected to ensure that the pool is self-supporting, but in no event could it be higher than 150% of average premium rates for individual standard risks in the state for comparable coverage. To the extent the insurance pool is not self-supporting from premiums, losses would be made up by equitable assessments on all participating employers in the state.

The state insurance pool would not be permitted to establish a life-time limit on benefits of less than \$500,000 and would have to cap annual out-of-pocket expenses for covered services at no more than \$1,500 for individual coverage and \$3,000 for family coverage. A choice of deductibles could be offered but could not exceed \$1,000 for each covered individual.

Exclusions of coverage for preexisting conditions would be permitted but for no more than 6 months. Covered services offered under the plan would be required to include the purchase and repair of medically necessary durable medical equipment.

The Committee realizes that the state health insurance pools defined under this provision are generally designed for people who can afford to pay the premiums. A state or other entity would be

permitted to provide payment of part or all of the premium of an enrollee and could vary the amount of the payment based on the enrollee's income or on some other basis.

Based upon testimony, pool losses ranged from \$0.50 to \$1.40 per person covered by health insurance in the states having pools in place. The Committee therefore believes, based on the experience of the states which have enacted similar legislation, that the general losses will be small.

The Committee anticipates that the establishment of these health insurance pools will take some pressure off the need for new or existing public programs for people who do not have access to health insurance.

The Committee bill intends that each State should establish a pool by not later than January 1, 1988, or if later, the end of the first regular State legislative session that begins after the date of enactment of this Act.

Effective date.—The proposal would be effective for taxable years beginning on or after January 1, 1988.

2. *COBRA technical amendments relating to continuation of employer-based health insurance coverage (sec. 10252 of the bill)*

Present law.—Section 10001 of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) amended the Internal Revenue Code to require that group health plans of covered employers provide qualified beneficiaries the opportunity to continue health care coverage under the plan if they paid up to 102% of the applicable premium in certain instances where coverage under the employer-based health plan would otherwise be terminated. The continuation coverage amendments apply to plan years beginning on or after July 1, 1986. In the case of collectively bargained plans, the amendments do not apply to plan years beginning before the later of (1) the date on which the last collective bargaining agreement relating to the plan terminates, or (2) January 1, 1987.

(a) *Modification of coverage*—Under current law the coverage must consist of coverage which is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.

(b) *Maximum period of continuation coverage*—Under current law the maximum period of continuation coverage relating to terminations and reduced hours is 18 months and for divorced, legally separated, medicare ineligible spouses and their dependents and dependents who lose their dependent status under the plan 36 months. No provision was made for multiple qualifying events. These time periods are the general rule unless the employer ceases to provide any group health plan to any employee, the qualified beneficiary fails to pay the premium in a timely manner or becomes a covered employee under any other group health plan, or becomes entitled to medicare, or remarries and is covered under another group health plan.

(c) *Grace period for payment of premiums*—Under current law coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary. No specific time period is specified.

(d) Election of beneficiaries—Under current law each qualified beneficiary is entitled to a separate election but a spouse of a covered employee or a covered employee can elect coverage on behalf of any other qualified beneficiary in the family who would lose coverage under the plan by reason of the qualifying event.

(e) Notice requirement—Under current law the employer of an employee under a plan must notify the plan administrator within thirty days of a qualifying event if the qualifying event is the death of the employee, the termination (other than by reason of such employee's gross misconduct), or reduction of hours of the covered employee's employment, or if the covered employee becomes entitled to medicare. Divorced or legally separated spouses and dependent children ceasing to be dependents under the plan are required to notify the plan administrator of the occurrence of such events but no time limit was established for notifying the plan administrator.

Explanation of provision.—(a) Modification of coverage—The general rule is that in all respects qualified beneficiaries are to be treated under the plan as similarly situated beneficiaries for whom a qualifying event has not taken place. For example, if the plan provides for an open enrollment period then qualified beneficiaries must be able to elect in the same manner as active employees. This means that a qualified beneficiary by reason of being a spouse of a covered employee would have the same rights as active employees during an open enrollment period and would not be limited to the rights of spouses of covered employees. By health benefits, the Committee means to include health benefit plans that include dental and vision care as defined in Sec. 213 of the Internal Revenue Code. This does not mean that an employer could compel the qualified beneficiary to pay for non-core benefits even if active employees have to accept core and non-core services under the plan.

(b) Maximum period of continuation coverage—The bill clarifies that a qualified beneficiary may have more than one qualifying event which entitles the beneficiary to continuation coverage but in no case may the coverage period with respect to such events (other than the period applicable to a qualifying event described in paragraph (3) (F) of the law) exceed a 36-month period. For example, a qualified beneficiary retires and then dies or is divorced, the qualified beneficiary spouse then has a second qualifying event which entitles this spouse to a total of 36 months of continuation coverage. However, the second qualifying event must take place during the period of coverage of the first qualifying event to be eligible for a total of 36 months from the date of the first qualifying event.

(c) Grace period for payment of premiums—The bill clarifies that the grace period is the longer of three periods: 30 days, the period the plan allows employees, or the period the insurance company allows the plan or employer whichever the case may be.

(d) Election by beneficiaries—The Committee bill clarifies that each qualified beneficiary is entitled to a separate election. The Committee realizes that normally an employed worker will elect coverage for the entire family. If the covered employee does not elect continuation coverage, however, the spouse and or dependent children are entitled to elect coverage. Moreover, even if the em-

ployee elects certain coverage, the spouse and or dependents may elect different coverage.

(e) Notice requirement.—The Committee bill establishes a 60-day notification period for divorced or legally separated spouses of covered employees or dependent children ceasing to be dependent children under the generally applicable requirements of the plan, to notify the plan administrator of such qualifying events.

Effective date.—The amendments made by these provisions are effective as if they had been included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985.

3. Continuation coverage for retirees in cases of bankruptcies (sec. 10253 of the bill)

Present law.—Section 10001 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) entitles employees covered under the employer's health plan who terminate employment up to 18 months of continuation coverage under the employer plan if they pay up to 102% of the applicable premium. However, this provision is only effective for an employer health plan year that begins on or after July 1, 1986. A special rule is provided for collectively bargained plans. Current law makes no provision for retirees who retire before the employer's new health plan year begins on or after July 1, 1986. Current law also does not include as a qualifying event, for purposes of triggering the continuation option, an employer filing for Title 11 bankruptcy proceedings.

Explanation of provision.—The bill would amend section 10001 of COBRA to include a new qualifying event, a new class of qualified beneficiaries and a new period of coverage for certain retirees, their spouses and dependent children and widows. Specifically, the legislation would define as a qualifying event, with respect to the employer from whose employment the covered employee retired at any time, the filing of a proceeding in a case under Title 11, U.S. Code, commencing on or after July 1, 1986. In order to be considered a qualifying event, the proceeding would have to result in a substantial elimination of coverage for the qualified beneficiary as defined below.

In the case of such a qualifying event a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary, as described below, within one year before or after the date of commencement of the Title 11 proceeding. For example, an employer contemplating filing for Title 11 bankruptcy proceedings may not in the year before or after filing for Title 11, reduce the health insurance coverage so that it offers minimal coverage. Such a reduction in health insurance coverage for retirees, their spouses and dependent children and widows, would trigger the continuation coverage provision included in this legislation.

The Committee is concerned that retirees who retire before the COBRA provision becomes effective for the employer's plan year beginning on or after July 1, 1986, might lose their employer-based health insurance, if the employer filed for Title 11 bankruptcy proceedings.

In the case of a qualifying event resulting from an employer filing for Title 11 bankruptcy proceedings, a qualified beneficiary would be defined as including a covered employee who retired on

or before the date of substantial elimination of coverage and any other individual who, on the day before the qualifying event, is a beneficiary under the plan: (1) as the spouse of the covered employee, (2) as the dependent child of the covered employee, or (3) as the surviving spouse of the covered employee. The term covered employee means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer. This means that the definition of covered employee includes an individual who has retired from employment from the employer and is receiving health benefits from that employer.

A qualified beneficiary who had retired on or before July 1, 1986, as described in the above paragraph, the spouse and dependent children and the widow of such a retired qualified beneficiary who were also qualified beneficiaries under the plan on the day before the qualifying event are entitled to elect to continue in the employer-based health insurance plan until the death of the covered employee. A surviving spouse who was a qualified beneficiary under the plan on the day before the qualifying event is entitled to elect continuation coverage until death. However, after the date of the death of the covered employee a new qualifying event is triggered which would entitle the surviving spouse and dependent children who are qualified beneficiaries of the covered employee to elect 36 months of continuation coverage.

As defined in section 10001 of COBRA, coverage ceases on: (1) the date on which the employer ceases to provide any group health plan to any employee, (2) failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary, (3) reemployment resulting in a covered employee being covered under any other group health plan or (4) remarriage resulting in coverage under a group health plan. However, entitlement to medicare coverage does not terminate coverage with respect to qualified beneficiaries in the case of a qualifying event resulting from an employer filing for Title 11 bankruptcy proceedings. It is the intent of this provision to override the general effective date of section 10001 of COBRA and the collective bargaining agreement effective date of COBRA.

Notwithstanding this legislation, the Committee understands the contractual obligation of some employers that have filed for Title 11 bankruptcy is very clear and that they cannot divest themselves of the obligation to provide retiree health insurance. The Committee bill includes this provision because the contractual obligation may not be as clear in other cases. By including this provision in the bill the Committee does not intend to express any opinion as to the additional rights or obligations that may exist under collective bargaining agreements or any other Federal or state law.

Effective date.—In general this legislation takes effect as if included in section 10001 of COBRA. However, the legislation shall apply in the case of plan years ending during the twelve month period beginning July 1, 1986, in the case of a qualifying event resulting from an employer filing for Title 11 bankruptcy proceedings as defined above or relating to the death of the covered employee occurring after July 1, 1986. A special transition rule applies to covered employees who have died after July 1, 1986.

Subtitle D.—Revenue Provisions

1. *Extension of telephone excise tax (secs. 10301 and 10302 of the bill)*

Present law.—A three-percent excise tax is imposed on amounts paid for local telephone service, toll telephone service, and teletype-writer exchange service (Code sec. 4251). The tax is paid by the service-recipient to the person rendering the service; the service-provider in turn remits the tax to the Federal Government.

Exemptions from the tax are provided for communications services furnished to news services (except local telephone service to news services), international organizations, the American National Red Cross, servicemen in combat zones, nonprofit hospitals and educational organizations, and State and local governments. Other exemptions are provided for amounts paid for installation charges and for certain calls from coin-operated telephones (sec. 4253). The tax does not apply to private communications systems (sec. 4252(d)).

Under present law, this excise tax is scheduled to terminate, effective with respect to amounts paid pursuant to bills first rendered after December 31, 1987.

Explanation of provision.—The bill extends the telephone excise tax at a three-percent rate for two years, through December 31, 1989.

The bill further requires the Treasury Department to study the possible effects of this tax in encouraging businesses to create their own, private telecommunications systems, bypassing regulated commercial carriers. This study is to consider the loss of excise tax receipts as a result of such systems and the appropriateness of continuing the present-law exemptions for private communications services and for other specified purposes or entities. The study is to be submitted to the Committee on Ways and Means and the Committee on Finance before January 1, 1988.

Effective date.—This provision is effective on the date of enactment.

III. COST ESTIMATES

A. Committee Estimate

Table 1 below summarizes the budget effects of the spending and tax provisions of the Committee's recommendation under the same economic and baseline assumptions used in the fiscal year 1987 budget resolution. These estimates are identical to those made by the Congressional Budget Office and the Joint Committee on Taxation. The budget effect includes all impacts the provision may have on other programs. For example, many of the Medicare and AFDC provisions have impacts upon the Medicaid program.

Aggregate savings over the 3-year period from fiscal 1987 to 1989 of the Committee's recommendations are in excess of the reconciliation instruction given to the Committee in the fiscal year 1987 budget resolution. The budget resolution assumed additional spending because it assumed the Committee would lower the inpatient hospital deductible. Thus, as shown in Table 1, net deficit reduction assumed by the resolution was \$11.6 billion. Total net deficit reduction achieved by the Committee's recommendations over the three-

year period from fiscal year 1987 to 1989 is \$12.0 billion, some \$.4 billion above the savings assumed in the resolution.

TABLE 1.—OUTLAY AND REVENUE PROVISIONS AS RECOMMENDED BY THE COMMITTEE ON WAYS AND MEANS RELATED TO THE REQUIREMENTS OF THE FISCAL YEAR 1987 BUDGET RESOLUTION

[Savings, in millions]

	Fiscal year—			
	1987	1988	1989	3-year total
A. Budget Resolution Targets				
Reconciliation instruction.....	\$4,350	\$4,095	\$4,190	\$12,635
Allowed spending	(250)	(400)	(350)	(1,000)
Net deficit reduction	4,100	3,695	3,840	11,635
B. Committee Recommendations				
Social Security:				
Remove COLA Trigger				
Accelerate state & local deposit of payroll taxes.....	394	294	1,158	1,846
Public Assistance:				
AFDC—UP	0	(115)	(255)	(370)
FY 1987 Federal AFDC percentage	(15)			(15)
IEVS targeting.....				
FUTA repayment tax extension.....	0	903	1,247	2,150
Medicare:				
Set Hospital deductible at \$500 in 1987	(580)	(230)		(810)
Hospital payment increases of 1.3 for fiscal year 1987 and market basket minus 2.0 percent for fiscal year 1988.....	250	1,100	1,320	2,670
Limit aggregate capital payment increases to 10 percent annually.....	155	355	590	1,100
Include Puerto Rico into PPS system.....	(10)	(15)	(20)	(45)
Quality protections	(74)	(95)	(193)	(362)
Medicare off-budget in 1987				
Eliminate periodic interim payments with prompt pay for providers.....	1,970	(480)	130	1,620
HMO amendments:				
Eliminate HMO 2-for-1 rule.....	(25)	(50)	(45)	(120)
Extend part B 25 percent premium policy for 1 year.....	0	0	440	440
Extend and modify limits on physician fee increase	(55)	(45)	50	(50)
Programs to increase physician participation*		100	100	200
Disallow administrative regulation on overpriced procedures and require study				
Reduce rates to ESRD facilities and physicians and strengthen networks.....	92	100	105	297
Technical amendments and miscellaneous provisions				
High risk health insurance pools.....				
COBRA health insurance amendments.....				
Revenues:				
Extend telephone excise tax for 2 years.....	0	1,337	2,290	3,627
Total (net deficit reductions).....	2,102	3,059	6,817	11,978

* Not included in totals. Dollar amounts determined by appropriation action.

Note: Numbers in parenthesis indicate the provision will cost not save money.

B. CBO estimates

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 28, 1986.

Hon. DAN ROSTENKOWSKI,
Chairman, Committee on Ways and Means,
U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimates of the provisions in the House Committee on Ways and Means reconciliation package. Provisions with no outlay or revenue effect are not listed in the tables. The estimates are shown in two separate attachments—one showing estimated outlay effects and one showing estimated revenue effects.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,
Sincerely,

RUDOLPH G. PENNER, *Director.*

TABLE 1.—THE ESTIMATED REVENUE EFFECTS OF THE COMMITTEE ON WAYS AND MEANS RECONCILIATION PROVISIONS RELATIVE TO THE BUDGET RESOLUTION BASE

[Fiscal years, in billions of dollars]

	1987	1988	1989	3-year total
Extend telephone excise tax for 2 years, net.....		1.337	2.290	3.627
Extend FUTA repayment tax for two years.....		.903	1.247	2.150
Accelerate state and local Social Security deposits.....	.394	.294	1.158	1.846
Eliminate 3 percent trigger for cost-of-living increases.....	0	0	0	0
Total revenue effect, net.....	.394	2.534	4.695	7.623

TABLE 2.—ESTIMATED OUTLAY EFFECTS OF THE COMMITTEE ON WAYS AND MEANS RECONCILIATION BILL RELATIVE TO THE BUDGET RESOLUTION BASELINE

[By fiscal year, in millions of dollars]

Provisions	1987	1988	1989	3-Year total
Subtitle A—OASDI Provisions				
Direct Spending: Eliminate trigger for COLA's.....	(1)	(1)	(1)	(1)
Subtitle B—Provisions Relating to Public Assistance and Unemployment Taxes				
Direct Spending:				
Mandate AFDC:				
Budget authority.....	0	115	255	370
Outlays.....	0	115	255	370
Hold harmless 1987 change in Federal match rate:				
Budget authority.....	15	0	0	15
Outlays.....	15	0	0	15
Amended Income Verification:				
Budget authority.....	(2)	(2)	(2)	(2)
Outlays.....	(2)	(2)	(2)	(2)

TABLE 2.—ESTIMATED OUTLAY EFFECTS OF THE COMMITTEE ON WAYS AND MEANS RECONCILIATION BILL RELATIVE TO THE BUDGET RESOLUTION BASELINE—Continued

(By fiscal year, in millions of dollars)

Provisions	1987	1988	1989	3-Year total
Subtitle C—Medicare and Health Programs (Part A of Medicare would be off-budget as a result of this legislation)				
Direct Spending:				
PART 1—PROVISIONS RELATING TO MEDICARE PART A ONLY				
Limit 87 deductible to \$500:				
Budget authority	—60	—85	—90	—235
Outlays	580	230	0	810
Limit Hospital increase (1.3 percent in 87, mb-2 in 88):				
Budget authority	10	80	195	285
Outlays	—250	—1,100	—1,320	—2,670
Limit capital—86 plus 10 percent, 20 percent, and 30 percent PPS Facilities only:				
Budget authority	10	35	80	125
Outlays	—155	—355	—590	—1,100
Puerto Rico:				
Budget authority	0	—5	—5	—10
Outlays	10	15	20	45
Quality bill—Part A:				
Budget authority	—5	—10	—20	—35
Outlays	58	70	167	295
PART 2—PROVISIONS RELATING TO MEDICARE PARTS A AND B				
PIP/prompt pay:				
Budget authority	96	920	320	1,335
Outlays	—1,970	480	—130	—1,620
HMO 2 for 1 rule:				
Budget authority	30	55	45	130
Outlays	25	50	45	120
Quality bill:				
Budget authority	2	1	1	4
Outlays	6	8	8	22
PART 3—PROVISIONS RELATING TO MEDICARE PART B				
Part B premiums set at 25 percent in 1989:				
Budget authority	0	0	—440	—440
Outlays	0	0	—440	—440
Physician increase, nonpar 3.2 percent and pars at 4.2 percent				
Budget authority	50	30	—70	10
Outlays	55	45	—50	50
ESRD:				
Budget authority	—98	—103	—108	—309
Outlays	—92	—100	—105	—297
PART 4—IMPROVED REVIEW OF QUALITY BY PROs				
Improved review by PROs:				
Budget authority	3	4	4	11
Outlays	10	17	18	45
PART 5—ASSURING ACCESS TO HEALTH CARE				
Continue covering retirees in cases of bankruptcies:				
Budget authority	(2)	(2)	(2)	(2)
Outlays	(2)	(2)	(2)	(2)
Authorization:				
PART 3—PROVISIONS RELATING TO MEDICARE PART B				
Physician participation: Outlays	0	100	100	200

TABLE 2.—ESTIMATED OUTLAY EFFECTS OF THE COMMITTEE ON WAYS AND MEANS RECONCILIATION BILL RELATIVE TO THE BUDGET RESOLUTION BASELINE—Continued

[By fiscal year, in millions of dollars]

Provisions	1987	1988	1989	3-Year total
Total—Direct spending (on and off budget):				
Budget authority	52	1,037	167	1,256
Outlays	-1,708	-525	-2,122	-4,355
Total—Authorizations:	0	100	100	200

¹ No change relative to CBO baseline that assumes the payment of a 3.4% COLA.² Less than \$500,000.

Note.—This table summarizes the bill's estimated impact on the federal budget, relative to both current law and budget resolution baseline, as adjusted for enacted legislation. The House Budget Committee has specified that reconciliation savings are to be measured from the baseline used by the budget conferees adjusted for subsequently enacted legislation.

IV. ADDITIONAL VIEWS OF MR. FRENZEL

The Ways and Means Committee's reconciliation action fell \$2 billion short of its reconciliation target for FY 1987. It ought to be rejected by the Budget Committee, the Rules Committee and the House.

Despite its inadequacies, the Ways and Means reconciliation won't be rejected. Instead, victory will be declared because the 3 year reconciliation savings do achieve the \$11.6 billion target.

In my judgment, the first year, FY 1987, is the only one that counts. If we can't meet our Gramm-Rudman-Hollings objective in 1987, we surely aren't going to meet it in 1988 or 1989.

The Committee has fallen short, therefore, of its most important obligation. That isn't good news, but it isn't as bad as what follows.

The bad news is the way in which the Committee achieved its 3 year target. About half of it is in new taxes.

The new taxes are an extension of telephone taxes totaling \$3.6 billion, and an extension of FUTA taxes of \$2.2 billion. The telephone tax, of course, falls most heavily on individual consumers.

The FUTA tax, a $\frac{2}{10}$ of 1% levy of payroll to pay the debt of an overambitious unemployment compensation program of the mid-1970s, is a burden that discourages employers from hiring new employees. A payroll tax is inevitably, a tax on jobs. This one should be allowed to expire in mid 1987 when the debt is paid off.

Not meeting the target is once; inflicting new taxes is twice; but the Committee really struck out when it included new programs in its reconciliation bill. One such adventure made mandatory a now discretionary state AFDC program costing nearly \$400 million.

When a responsible committee like Ways and Means adds new programs, other more profligate committees seize on that action to add new programs of their own.

Overall, the Committee's reconciliation bill is inadequate, unfair, and mischievous. It should be rejected. The Committee should be directed to make real spending reductions without new taxes or new programs.

BILL FRENZEL.

CHANGES IN EXISTING LAW

In compliance with clause 3 of the rule XIII of the Rules of the House of Representatives, as amended, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in *italic*, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * *

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

* * * * *

DEFINITION OF EMPLOYMENT

SEC. 210. For the purposes of this title—

Employment

(a) * * *

MEDCARE QUALIFIED GOVERNMENT EMPLOYMENT

(p)(1) * * *

(2) Service shall not be treated as employment by reason of paragraph (1)(B) if the service is performed—

(A) * * *

* * * * *

[(C) by an individual, as an employee of a State or political subdivision thereof or of the District of Columbia, serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency, [or]

(D) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or a medical or dental resident in training[.], or

(E) *by an election official or election worker if the remuneration paid in a calendar year for such service is less than \$100.*

* * * * *

TITLE VII—ADMINISTRATION

* * * * *

BUDGETARY TREATMENT OF TRUST FUND OPERATIONS

SEC. 710. (a) * * *

[(b) The disbursements of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund shall be treated as a separate major functional category in

the budget of the United States Government as submitted by the President and in the congressional budget, and the receipts of such Trust Funds, including the taxes imposed under sections 1401(b), and 3111(b) of the Internal Revenue Code of 1954, shall be set forth separately in such budgets.】

(b)(1) The receipts and disbursements of the Federal Hospital Insurance Trust Fund and the taxes imposed under sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1954, shall not be included in the totals of the budget of the United States Government as submitted by the President or of the congressional budget and shall be exempt from any general budget limitation imposed by statute on expenditures and net lending (budget outlays) of the United States Government.

(2) The disbursements of the Federal Supplementary Medical Insurance Trust Fund shall be treated as a separate major functional category in the budget of the United States Government as submitted by the President and in the congressional budget, and the receipts of such Trust Fund shall be set forth separately in such budgets.

(c) No provision of law enacted after the date of the enactment of the Balanced Budget and Emergency Deficit Control Act of 1985 (other than a provision of an appropriation Act that appropriates funds authorized under the Social Security Act as in effect on the date of the enactment of the Balanced Budget and Emergency Deficit Control Act of 1985) may provide for payments from the general fund of the Treasury to the Federal Old-Age and Survivors Insurance Trust Fund [or] , the Federal Disability Insurance Trust Fund, [or for payments from either] or the Federal Hospital Insurance Trust Fund, or for payments from any such Trust Fund to the general fund of the Treasury.

* * * * *

TITLE XI—GENERAL PROVISIONS AND PEER REVIEW

* * * * *

PART A—GENERAL PROVISIONS

* * * * *

CIVIL MONETARY PENALTIES

SEC. 1128A. (a) Any person (including an organization, agency, or other entity) that—

(1) presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection [(h)(1)] (i)(1), a claim (as defined in subsection [(h)(2)] (i)(2) that the Secretary determines is for a medical or other item or service—

(A) that the person knows or has reason to know was not provided as claimed, or

(B) payment for which may not be made under the program under which such claim was made, pursuant to a determination by the Secretary under section 1128, 1160(b),

or 1862(d), or pursuant to a determination by the Secretary under section 1866(b)(2) with respect to which the Secretary has initiated termination proceedings; or

* * * * *

(b)(1) If a hospital or an eligible organization with a risk-sharing contract under section 186 knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals who—

(A) are entitled to benefits under part A or part B of title XVIII,

(B) in the case of an eligible organization, are enrolled with the organization, and

(C) are under the direct care of the physician, the hospital or organization shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$2,000 for each such individual with respect to whom the payment is made.

(2) Any physician who knowingly accepts receipt of a payment described in paragraph (1) shall be subject, in addition to any other penalties that may be prescribed by laws, to a civil money penalty of not more than \$2,000 for individual described in such paragraph with respect to whom the payment is made.

[(b)] *(c)(1) The Secretary may initiate a proceeding to determine whether to impose a civil money penalty or assessment under subsection (a) or (b) only as authorized by the Attorney General pursuant to procedures agreed upon by them.*

(2) The Secretary shall not make a determination adverse to any person under subsection (a) or (b) until the person has been given written notice and an opportunity for the determination to be made on the record after a hearing at which the person is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the person.

[(c)] *(d) In determining the amount or scope of any penalty or assessment imposed pursuant to subsection (a) or (b), the Secretary shall take into account—*

(1) the nature of claims and the circumstances under which they were presented,

(2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims, and

(3) such other matters as justice may require.

[(d)] *(e) Any person adversely affected by a determination of the Secretary under this section may obtain a review of such determination in the United States Court of Appeals for the circuit in which the person resides, or in which the claim was presented, by filing in such court (within sixty days following the date the person is notified of the Secretary's determination) a written petition requesting that the determination be modified or set aside. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, and thereupon the Secretary shall file in the Court the record in the proceeding as provided in section 2112 of title 28, United States Code. Upon such filing, the court shall have jurisdiction of the proceeding and of the question determined therein, and shall have the power to make and enter upon the plead-*

ings, testimony, and proceedings set forth in such record a decree affirming, modifying, remanding for further consideration, or setting aside, in whole or in part, the determination of the Secretary and enforcing the same to the extent that such order is affirmed or modified. No objection that has not been urged before the Secretary shall be considered by the court, unless the failure or neglect to urge such objection shall be excused because of extraordinary circumstances. The findings of the Secretary with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive. If any party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the hearing before the Secretary, the court may order such additional evidence to be taken before the Secretary and to be made a part of the record. The Secretary may modify his findings as to the facts, or make new findings, by reason of additional evidence so taken and filed, and he shall file with the court such modified or new findings, which findings with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive, and his recommendations, if any, for the modification or setting aside of his original order. Upon the filing of the record with it, the jurisdiction of the court shall be exclusive and its judgment and decree shall be final, except that the same shall be subject to review by the Supreme Court of the United States, as provided in section 1254 of title 28, United States Code.

[(e)] (f) Civil money penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in United States district court for the district where the claim was presented, or where the claimant resides, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1)(A) In the case of amounts recovered arising out of a claim under title XIX, there shall be paid to the State agency an amount equal to the State's share of the amount paid by the State agency for such claim.

(B) In the case of amounts recovered arising out of a claim under an allotment to a State under title V, there shall be paid to the State agency an amount equal to three-sevenths of the amount recovered.

(2) Such portion of the amounts recovered as is determined to have been paid out of the trust funds under sections 1817 and 1841 shall be repaid to such trust funds.

(3) The remainder of the amounts recovered shall be deposited as miscellaneous receipts of the Treasury of the United States.

The amount of such penalty or assessment, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States or a State agency to the person against whom the penalty or assessment has been assessed.

[(f)] (g) A determination by the Secretary to impose a penalty or assessment under section (a) or (b) shall be final upon the expiration of the sixty-day period referred to in subsection (d). Matters that were raised or that could have been raised in a hearing before the Secretary or in an appeal pursuant to subsection [(d)] (e) may not be raised as a defense to a civil action by the United States to collect a penalty or assessment assessed under this section.

[(g)] (h) Whenever the Secretary's determination to impose a penalty or assessment under subsection (a) or (b) becomes final, he shall notify the appropriate State or local medical or professional organization, and the appropriate utilization and quality control peer review organization, and the appropriate State or local licensing agency or organization (including the agency specified in sections 1864(a) and 1902(a)(33)) that such a penalty or assessment has become final and the reasons therefor.

[(h)] (i) For the purposes of this subsection:

(1) The term "State agency" means the agency established or designated to administer or supervise the administration of the State plan under title XIX of this Act or designated to administer the State's program under title V of this Act.

(2) The term "claim" means an application submitted by—

(A) a provider of services or other person, agency, or organization that furnishes an item or service under title XVIII of this Act, or

(B) a person, agency, or organization that furnishes an item or service for which medical assistance is provided under title XIX of this Act, or

(C) a person, agency, or organization that provides an item or service for which payment is made under title V of this Act or from an allotment to a State under such title, to the United States or a State agency or agent thereof, for payment for health care services under title XVIII or XIX of this Act or for any item or service under title V of this Act.

(3) The term "item or service" includes (A) any particular item, device, medical supply, or service claimed to have been provided to a patient and listed in an itemized claim for payment, and (B) in the case of a claim based on costs, any entry in the cost report, books of account or other documents supporting such claim.

(4) The term "agency of the United States" includes any contractor acting as a fiscal intermediary, carrier, or fiscal agent or any other claims processing agent for a health insurance or medical services program under title XVIII or XIX of this Act.

* * * * *

DEFINITION OF UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATION

SEC. 1152. The term "utilization and quality control peer review organization means an entity which—

(1)(A) is composed of a substantial number of the licensed doctors of medicine and osteopathy engaged in the practice of medicine or surgery in the area and who are representative of the practicing physicians in the area, designated by the Secre-

tary under action section 1153, with respect to which the entity shall perform services under this part, or (B) has available to it, by arrangement or otherwise, the services of a sufficient number of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area to assure that adequate peer review of the services provided by the various medical specialties and subspecialties can be assured; [and]

(2) is able, in the judgment of the Secretary, to perform review functions required under section 1154 in a manner consistent with the efficient and effective administration of this part and to perform reviews of the pattern of quality of care in an area of medical practice where actual performance is measured against objective criteria which define acceptable and adequate practice; [and]

(3) has at least one individual who is a representative of consumers on its board of directors.

CONTRACTS WITH UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATIONS

SEC. 1153. (a) * * *

* * * * *

(g) *The Secretary shall provide that peer review organizations receive each month, on a timely basis, either directly from hospitals or through fiscal intermediaries data necessary to initiate the review process under section 1154(a) on a timely basis.*

FUNCTIONS OF PEER REVIEW ORGANIZATIONS

SEC. 1154. (a) Any utilization and quality control peer review organization entering into a contract with the Secretary under this part must perform the following functions:

(1) * * *

(4) (A) The organization shall, after consultation with the Secretary, determine the types and kinds of cases (whether by type of health, care or diagnosis involved, or whether in terms of other relevant criteria relating to the provision of health care services) with respect to which such organization will, in order to most effectively carry out the purposes of this part, exercise review authority under the contract. The organization shall notify the Secretary periodically with respect to such determinations. *Each peer review organization shall provide that a reasonable proportion of its activities are involved with reviewing, under paragraph (1)(B), the quality of services and that a reasonable allocation of such activities relating to quality of services is made among the different cases and settings (including inpatient hospital care, post-acute-care settings, ambulatory settings, health maintenance organizations, and competitive medical plans). In establishing such allocation, the organization shall consider (i) whether there is reason to believe that there is a particular need for review of particular cases or settings because of previous problems regarding quality of care, (ii) the cost of such reviews and the likely yield of such reviews in*

terms of number and seriousness of quality of care problems likely to be discovered as a result of such reviews, and (iii) the availability and adequacy of alternative quality review and assurance mechanisms.

(B) The contract of each organization shall provide for the review of services (including both inpatient and outpatient services) provided by eligible organizations pursuant to a contract under section 1876 for the purpose of determining whether the quality of such services meets professional recognized standards of health care, including whether appropriate health care services have failed to be provided or have been provided in inappropriate settings. Under the contract the level of effort expended by the organization on reviews under this subparagraph shall be equivalent, on a per enrollee basis, to the level of effort expended by the organization on utilization and quality reviews performed by the organization with respect to individuals not enrolled with an eligible organization.

* * * * *

(13) Notwithstanding paragraph (4), the organization shall perform the review described in paragraph (1) with respect to early readmission cases to determine if the previous inpatient hospital services and the post-hospital services met professionally recognized standards of health care. Such reviews may be performed on a sample basis if the organization and the Secretary determine it to be appropriate. In this paragraph, an "early readmission case" is a case in which an individual, after discharge from a hospital, is readmitted to a hospital less than 31 days after the date of the most recent previous discharge.

(14) The organization shall conduct an appropriate review of all written complaints about the quality of services (for which payment may otherwise be made under title XVIII) not meeting professionally recognized standards of health care, if the complaint is filed with the organization by an individual entitled to benefits for such services under such title (or a person acting on the individual's behalf). The organization shall inform the individual (or representative) of the organization's conclusions respecting the complaint and final disposition of the complaint. Before the organization concludes that the quality of services does not meet professionally recognized standards of health care, the organization must provide the practitioner or person concerned with reasonable notice and opportunity for discussion.

* * * * *

(d)(1) If—

(A) a hospital has determined that a patient no longer requires inpatient hospital care, and

(B) the attending physician has agreed with the hospital's determination,

the hospital may provide the patient (or the patient's representative) with a notice (meeting conditions prescribed by the Secretary under section 1879) of the determination.

(2) If—

(A) a hospital has determined that a patient no longer requires inpatient hospital care, but

(B) the attending physician has not agreed with the hospital's determination,
the hospital may request the appropriate peer review organization to review under subsection (a) the validity of the hospital's determination.

(3)(A) If a patient (or a patient's representative)—

(i) has received a notice under paragraph (1), and

(ii) requests the appropriate peer review organization to review the determination,

then, the organization shall conduct a review under subsection (a) of the validity of the hospital's determination and shall provide notice (by telephone and in writing) to the patient or representative and the hospital and attending physician involved of the results of the review. Such review shall be conducted regardless of whether or not the hospital will charge for continued hospital care or whether or not the patient will be liable for payment for such continued case.

(B) If a patient (or a patient's representative) requests a review under subparagraph (A) while the patient is still an inpatient in the hospital and not later than noon of the first working day after the date the patient receives the notice under paragraph (1), then—

(i) the hospital shall provide to the appropriate peer review organization the records required to review the determination by the close of business of such first working day, and

(ii) the peer review organization must provide the notice under subparagraph (A) by not later than one full working day after the date the organization has received the request and such records.

(4) If—

(A) a request is made under paragraph (3)(A) not later than noon of the first working day after the date the patient (or patient's representative) receives the notice under paragraph (1), and

(B) the conditions described in section 1879(a)(2) with respect to the patient or representative are met,
the hospital may not charge the patient for inpatient hospital services furnished before noon of the day after the date the patient or representative receives notice of the peer review organization's decision.

(5) In any review conducted under paragraph (2) or (3), the organization shall solicit the views of the patient involved (or the patient's representative).

(e) The Secretary, in consultation with appropriate experts, shall identify methods that would be available to assist peer review organizations (under subsection (a)(4)) in identifying those cases which are more likely than others to be associated with a quality of services which does not meet professionally recognized standards of health care.

* * * * *

PROHIBITION AGAINST DISCLOSURE OF INFORMATION

SEC. 1160. (a) * * *

(B) An organization having a contract with the Secretary under this part shall provide in accordance with procedures and safeguards established by the Secretary, data and information—

(1) which may identify specific providers or practitioners as may be necessary—

(A) * * *

(B) to assist appropriate Federal and State agencies recognized by the Secretary as having responsibility for identifying cases or patterns involving risks to the public health, which data and information shall be provided by the peer review organization to any such agency—

(i) at the discretion of the peer review organization, at the request of such agency relating to a specific case or pattern with respect to which such agency has made a finding, or has a reasonable belief, that there may be a substantial risk to the public health, or

(ii) upon a finding by, or the reasonable belief of, the peer review organization that there may be a substantial risk to the public health; [and]

[(C) to assist appropriate State agencies recognized by the Secretary as having responsibility for licensing or certification of providers or practitioners, which data and information shall be provided by the peer review organization to any such agency at the request of such agency relating to a specific case, but only to the extent that such data and information is required by the agency in carrying out a function which is within the jurisdiction of such agency under State law; and]

(C) to assist appropriate State agencies recognized by the Secretary as having responsibility for licensing or certification of providers or practitioners or to assist national accreditation bodies acting pursuant to section 1865 in accrediting providers for purposes of meeting the conditions described in title XVIII, which data and information shall be provided by the peer review organization to any such agency or body at the request of such agency or body relating to a specific case or to a possible pattern of substandard care, but only to the extent that such data and information are required by the agency or body in carrying out its respective function which is within the jurisdiction of the agency or body under State law or under section 1865; and

(D) to assist State ombudsmen and State protection and advocacy officials who the Secretary identifies as having responsibility for assuring the quality of care furnished by providers or practitioners, which data and information shall be provided by the peer review organization to any such ombudsman or official upon request relating to a specific provider or practitioner, but only to the extent that such data and information are related to the quality of care furnished by a provider or practitioner and only if the peer review organization determines that the data and information may reflect a failure in a substantial number of cases or a gross and flagrant failure in one or more instances to provide services of a quality which meets profes-

sionally recognized standards of health care, and that the data and information are needed by the ombudsman or official in carrying out official duties;

* * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * *

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * *

PAYMENT TO PROVIDERS OF SERVICES

SEC. 1815. (a) (1) The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

(2)(A) *Except as provided in subparagraph (B), the Secretary shall provide payment under this part for inpatient hospital service furnished by a subsection (d) hospital (as defined in section 1886(d)(1)(B), and including a distinct psychiatric or rehabilitation unit of such a hospital) only on the basis of actual bills submitted by the hospital and not on a periodic interim payment basis.*

(B) *Subparagraph (A) shall not apply, and the Secretary shall permit payment on a periodic interim payment basis—*

(i) *to a subsection (d) hospital during the period it is—*

(I) *being paid additional amounts under section 1886(d)(5)(F) (relating to disproportionate share payments), or*

(II) *a sole community hospital (as defined in section 1886(d)(5)(C)(ii)); and*

(ii) *to a hospital which is receiving payment under a State hospital reimbursement system under section 1814(b)(3) or 1886(c), if payment on a periodic interim payment basis is an integral part of such reimbursement system.*

(C) *In the case of a subsection (d) hospital which has significant cash flow problems resulting from operations of its intermediary or from unusual circumstances of the hospital's operation, the Secretary shall make available appropriate accelerated payments.*

* * * * *

USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE
PAYMENT TO PROVIDERS OF SERVICES

SEC. 1816. (a) * * *

* * * * *

(c) (1) An agreement with any agency or organization under this section may contain such terms and conditions as the Secretary finds necessary or appropriate, may provide for advances of funds to the agency or organization for the making of payments by it under subsection (a), and shall provide for payment of so much of the cost of administration of the agency or organization as is determined by the Secretary to be necessary and proper for carrying out the functions covered by the agreement. The Secretary shall provide that in determining the necessary and proper cost of administration, the Secretary shall, with respect to each agreement, take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated agency or organization in carrying out the terms of its agreement.

(2)(A) *Each agreement under this section shall provide that, in cases of claims for which payment under this part is not made on a periodic interim payment basis under section 1815(a)—*

(i) if payment is not made on or before the 22nd calendar day after the date on which a clean claim is received, interest on the claim shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made;

(ii) the agency or organization shall notify the entity submitting the claim within 22 calendar days after the date a claim is received, of any defect, impropriety, or circumstance that prevents the claim from being treated as a clean claim;

(iii) if notice required under clause (ii) is not provided on a timely basis with respect to a claim and payment is subsequently made on the claim, interest on the amount determined to be payable shall be made (at the rate described in clause (i)) for the period beginning on the day after the required notice date and ending on the date on which payment is made or the date the notice is provided, whichever date is earlier; and

(iv) the agency or organization will be reimbursed for the amount of interest paid under this subparagraph from amounts made available for Federal administrative costs to carry out this part (other than such amounts as are made available for intermediary agreements under this section).

(B) In this paragraph, the term "clean claim" means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this part.

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE
AGED AND DISABLED

* * * * *

COVERAGE PERIOD

SEC. 1838. (a) * * *

* * * * *

(b) An individual's coverage period shall continue until his enrollment has been terminated—

(1) by the filing of notice that the individual no longer wishes to participate in the insurance program established by this part, or

(2) or nonpayment of premiums.

The termination of a coverage period under paragraph (1) shall (except as otherwise provided in section 1843(e)) take effect at the close of the calendar quarter [following the calendar quarter] in which the notice is filed. The termination of a coverage period under paragraph (2) shall take effect on a date determined under regulations, which may be determined so as to provide a grace period in which overdue premiums may be paid and coverage continued. The grace period determined under the preceding sentence shall not exceed 90 days; except that it may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period.

Where an individual who is deemed to have enrolled for medical insurance pursuant to section 1837(f) files a notice before the first day of the month in which his coverage period begins advising that he does not wish to be so enrolled, the termination of the coverage period resulting from such deemed enrollment shall take effect with the first day of the month the coverage would have been effective. Where an individual who is deemed enrolled for medical insurance pursuant to section 1837(f) files a notice requesting termination of his deemed coverage in or after the month in which such coverage becomes effective, the termination of such coverage shall take effect at the close of the calendar quarter [following the calendar quarter] in which the notice is filed.

* * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a)(1) * * *

* * * * *

(e)(1) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month after December 1983 and prior to January [1989] 1990 shall be an amount equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such month.

(2) Any increases in premium amounts taking effect prior to January [1989] 1990 by reason of paragraph (1) shall be taken into ac-

count for purposes of determining increases thereafter under subsection(a)(3).

(f)(1) If no cost-of-living increase becomes effective under section 215(i) in December of 1985, 1986, [or 1987], 1987, or 1988, the monthly premium of each individual enrolled under this part for each month in the succeeding year shall (except as otherwise provided in subsection (b)) be the same as the monthly premium (disregarding subsection (b)) of the individual for such December.

(2) If paragraph (1) does not apply to the monthly premiums for 1986, 1987, [or 1988], 1988, or 1989, if an individual is entitled to monthly benefits under section 202 or 223 for November and for December in the preceeding year, and if the monthly premium for that December and for the following January is deducted from those benefits under section 1840(a)(1), the monthly premium for that individual for that January and for each of the succeeding 11 months for which he is entitled to benefits under section 202 or 223 shall (except as otherwise provided in subsection (b)) be the greater of—

(A) the monthly premium amount determined under subsection (a)(2) for that January reduced by the amount (if any) necessary to make the monthly benefits under section 202 or 223 for that December after the deduction of the monthly premium (disregarding subsection (b)) for that January at least equal to the monthly benefits under section 202 or 223 for the preceding November after the deduction of the premium (disregarding subsection (b)) for that individual for that December, or

(B) the monthly premium (disregarding subsection (b)) for that individual for that December.

For purposes of this subsection, retroactive adjustments or payments and deductions on account of work shall not be taken into account in determining the monthly benefits to which an individual is entitled under section 202 or 223.

* * * * *

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

* * * * *

(b)(1) * * *

* * * * *

(3) * * *

* * * * *

(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part, [and]

(F) will take such action as may be necessary to assure that where payment under this part for a service rendered is on a charge basis, payment shall be determined on the basis of the charge that is determined in accordance with this section on the basis of customary and prevailing charge levels in effect at

the time the service was rendered or, in the case of services rendered more than 12 months before the year (ending on September 30) in which the bill is submitted or request for payment is made, on the basis of such levels in effect for the 12-month period preceding such year;

(G) will provide such information to nonparticipating physicians as is available to enable the physicians to determine the maximum actual charges permitted under subsection (j)(1)(C); and

(H) if it makes determinations or payments with respect to physicians' services, will implement—

(i) programs to recruit and retain physicians as participating physicians in the area served by the carrier, including educational and outreach activities and the use of professional relations personnel to handle billing and other problems relating to payment of claims of participating physicians; and

(ii) programs to familiarize beneficiaries with the participating physician program and to assist such beneficiaries in locating participating physicians;

* * * * *

(4)(A)(i) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 15-month period beginning July 1, 1984, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

(ii)(I) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

(II) In determining the prevailing charge levels under the fourth sentence of paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall permit an additional one percentage point increase in the increase otherwise permitted under that sentence.

(III) In applying the percentage increase in the MEI for physicians' services furnished by a participating physician during each year after 1986, the Secretary shall provide a bonus of 1 percentage point in the percentage increase otherwise determined. Such a bonus for each year shall apply to physicians' services furnished only during the year and not in the calculation of payments for any subsequent year.

[(iii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 12-month period beginning on or after January 1, 1987, by a physician who is a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set

for services furnished during the previous calendar year (without regard to clause (ii)(II)) for physicians who were participating physicians during that year.】

(iii) In determining the maximum allowable prevailing charges which may be recognized consistent with the index described in fourth sentence of paragraph (3) for physicians' services furnished on or after January 1, 1987, by participating and nonparticipating physicians, respectively, the Secretary shall treat the maximum allowable prevailing charges recognized as of December 31, 1986, under such sentence with respect to participating and nonparticipating physicians, respectively, as having been justified by economic changes.

(iv) Beginning with 1987, the percentage increase in the MEI (as defined in subparagraph (E)(ii)) shall be the same for nonparticipating physicians as for participating physicians.

* * * * *

(C)【(i)】 In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during periods beginning after September 30, 1985, the Secretary shall treat the level as set under subparagraph (A)(i) as having fully provided for the economic changes which would have been taken into account but for the limitations contained in subparagraph (A)(i).

【(ii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the periods beginning after December 31, 1986, by a physician who was not a participating physician on that date, the Secretary shall treat the level as set under subparagraph (A)(ii) as having fully provided for the economic changes which would have been taken into account but for the limitations contained in subparagraph (A)(ii).】

(D)(i) In determining the customary charges for physicians services furnished during the 8-month period beginning May 1, 1986, or the 12-month period beginning January 1, 1987, by a physician who was not a participating physician (as defined in subsection (h)(1) on September 30, 1985, the Secretary shall not recognize increases in actual charges for services furnished during the 15-month period beginning on July 1, 1984, above the level of the physician's actual charges billed in the 3-month period ending on June 30, 1984.

(ii) In determining the customary charges for physicians' services furnished during the 12-month period beginning January 1, 1987, by a physician who is not a participating physician (as defined in subsection (h)(1)) on April 30, 1986, the Secretary shall not recognize increases in actual charges for services furnished during the 7-month period beginning on October 1, 1985, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984.

(iii) In determining the customary charges for physicians' services furnished during the 12-month period beginning January 1, 1987, or January 1, 1988, by a physician who is not a participating physician (as defined in subsection (h)(1)) on December 31, 1986, the Secretary shall not recognize increases in actual charges for services furnished during the 8-month period beginning on May 1, 1986,

above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984.

(iv) *In determining the customary charges for physicians' services furnished on or after January 1, 1988, if a physician was a nonparticipating physician in a previous year (beginning with 1987), the Secretary shall not recognize any amount of such charges for services furnished during such previous year that exceed the limit on actual charges imposed under subsection (j)(1)(C).*

(E) *In this section:*

(i) *The term "participating physician" refers, with respect to the furnishing of services, to a physician who at the time of furnishing the services is a participating physician (under subsection (h)(1)), and the term "nonparticipating physician" refers, with respect to the furnishing of services, a physician who at the time of furnishing the services is not a participating physician.*

(ii) *The term "percentage increase in the MEI" means, with respect to physicians' services furnished in a year, the percentage increase in the medical economic index (referred to in the fourth sentence of paragraph (3)) applicable to such services furnished as of the first day of that year.*

* * * * *

(8) The Secretary by regulation shall—

(A) describe the factors to be used by carriers in determining the cases (of particular items or services) in which the application of this subsection results in the determination of a reasonable charge that, by reason of its grossly excessive or grossly deficient amount, is not inherently reasonable, and

(B) provide in those cases for the factors that will be considered by carriers in establishing a reasonable charge that is realistic and equitable.

In the case of items and services other than physicians' services, a carrier shall only provide, in the process of calculating the prevailing charge for specific items and services, for not considering charges in specific instances in which the charges, in comparison with the charges for similar items and services, are grossly excessive or deficient. Nothing in this paragraph or this Act shall be construed as authorizing the Secretary, through regulations, guidelines, instructions, or otherwise, to require carriers to reduce payment amounts under this part for specific items and services for which the Secretary has made a specific determination that the payment amounts or charges are excessive. Nothing in this paragraph or this Act shall be construed as authorizing the Secretary, through regulations, guidelines, instructions, or otherwise, to require carriers to reduce payment amounts under this part for specific items and services for which the Secretary has made a specific determination that the payment amounts or charges are excessive.

* * * * *

(c)(1) Any contract entered into with a carrier under this section shall provide for advances of funds to the carrier for the making of payments by it under this part, and shall provide for payment of the cost of administration of the carrier, as determined by the Sec-

retary to be necessary and proper for carrying out the functions covered by the contract. The Secretary shall provide that in determining a carrier's necessary and proper cost of administration, the Secretary shall, with respect to each contract, take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated carrier in carrying out the terms of its contract.

(2)(A) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall that, in cases of claims for which payment under this part is not made on a periodic interim payment basis described in section 1815(a)—

(i) if payment is not made on or before the 22nd calendar day (or the 11th calendar day the case of a claim for services furnished by a participating physician or supplier) after the date on which a clean claim is received, interest on the claim shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made;

(ii) the carrier shall notify the entity submitting the claim, within 22 calendar days (or within 11 calendar days, in the case of a claim for services furnished by a participating physician or supplier) after the date the claim is received, of any defect, impropriety, or circumstance that prevents the claim from being treated as a clean claim;

(iii) if notice required under clause (ii) is not provided on a timely basis with respect to a claim and payment is subsequently made on the claim, interest on the amount determined to be payable shall be made (at the rate described in clause (i)) for the period beginning on the day after the required notice date and ending on the date on which payment is made or the date the notice is provided, whichever date is earlier; and

(iv) the carrier will be reimbursed for the amount of interest paid under this subparagraph from amounts made available for Federal administrative costs to carry out this part (other than such amounts as are made available for carrier contracts under this section).

(B) In this paragraph, the term "clean claim" means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstances requiring special treatment that prevents timely payment from being made on the claim under this part.

* * * * *

(h)(1) Any physician or supplier may voluntarily enter into an agreement with the Secretary to become a participating physician or supplier. For purposes of this section, the term "participating physician or supplier" means a physician or supplier (excluding any provider of services) who, before [the beginning of any year beginning with 1984] during the month of November before a year, enters into an agreement with the Secretary which provides that such physician or supplier will accept payment under this part on an assignment related basis for all items and services furnished to

individuals enrolled under this part during such year. In the case of a newly licensed physician or a physician who begins a practice in a new area, or in the case of a new supplier who begins a new business, or in such similar cases as the Secretary may specify, such physician or supplier may enter into such an agreement after the beginning of a year, for items and services furnished during the remainder of the year.

* * * * *

(4) At the beginning of each fiscal year the Secretary shall publish directories (for appropriate local geographic areas) containing the name, address, and specialty of all participating physicians and suppliers (as defined in subsection (h)(1)) for that area for that fiscal year. Each directory shall be organized to make the most useful presentation of the information (as determined by the Secretary) for individuals enrolled under this part. *Each participating physician directory for an area shall provide an alphabetical listing of all participating physicians practicing in the area and an alphabetical listing by specialty and locality of such physicians.*

(5) The Secretary shall promptly notify individuals enrolled under this part of the publication of [such] the directories and shall make [such] the appropriate area directory or directories available in each district and branch office of the Social Security Administration, in the offices of carriers, and to senior citizens organizations.

(6) The Secretary shall provide that [the] the directories shall be available for purchase by the public. The Secretary shall provide that each appropriate area directory is sent to each participating physician located in that area *and to each individual enrolled under this part and residing in that area and that an appropriate number of copies of each such directory is sent to hospitals located in the area. Such copies shall be sent free of charge.*

* * * * *

(j)(1) (A) In the case of a physician who is not a participating physician for items and services furnished during a portion of the 30-month period beginning July 1, 1984, the Secretary shall monitor the physician's actual charges to individuals enrolled under this part for physicians' services during that portion of that period. If such physician knowingly and willfully bills individuals enrolled under this part for actual charges in excess of such physician's actual charges for the calendar quarter beginning on April 1, 1984, the Secretary may apply sanctions against such physician in accordance with paragraph (2).

(B) *During any period, on or after January 1, 1987, during which a physician is a nonparticipating physician, the Secretary shall monitor each such physician's actual charges for physicians' services furnished to individuals enrolled under this part. If such physician knowingly and willfully bills for such services actual charges in excess of the charges permitted under subparagraph (C), the Secretary may apply sanctions against such physician in accordance with paragraph (2).*

(C) *For physicians' services furnished by a physician to individuals enrolled under this part—*

(i) during 1987, in the case of such services for which the physician—

(I) has actual charges for the calendar quarter beginning on April 1, 1984, the limit is the physician's actual charges for such services furnished during such quarter increased by the sum of the percentage increase in the MEI (as defined in subsection (b)(4)(E)) for 1987 and 1 percentage point, or

(II) has no actual charges for such calendar quarter, the limit is the 50th percentile of the customary charges (weighted by frequency of procedure) for the procedure performed by nonparticipating physicians in the locality during the 12-month period ending June 30, 1986, increased by the sum of the percentage increase in the MEI for 1987 and 1 percentage point; and

(ii) during a subsequent year, the limit is the maximum actual charges permitted under this subparagraph for the previous year increased by the percentage increase in the MEI for that subsequent year.

* * * * *

(2) Subject to paragraph (3), the sanctions which the Secretary may apply under paragraph (1) or subsection (k), (l), or (m) are—

(A) barring a physician from participation under the program under this title for a period not to exceed 5 years, in accordance with the procedures of paragraphs (2) and (3) of section 1862(d), or

(B) the imposition of civil monetary penalties and assessments, in the same manner as such penalties are authorized under section 1128A(a),

or both. No payment may be made under this title with respect to any item or service furnished by a physician during the period when he is barred from participation in the program under this title pursuant to this subsection.

(k)(1) If a physician knowingly and willfully *presents or causes to be presented a claim or bills* an individual enrolled under this part for charges for services as an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(2) If a physician knowingly and willfully *presents or causes to be presented a claim or bills* an individual enrolled under this part for charges that includes a charge for an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(1)(1)(A) Subject to subparagraph (C), if—

(i) a nonparticipating physician furnishes services to an individual enrolled for benefits under this part,

(ii) payment for such services is not accepted on an assignment related basis,

(iii) a carrier determines under this part or a peer review organization determines under part B of title XI that payment may not be made by reason of section 1862(a)(1), and

(iv) the physician has collected any amounts for such services, the physician shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts so collected.

(B) A refund under subparagraph (A) is considered to be on a timely basis only if—

(i) in the case of a physician who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the physician receives a denial notice under paragraph (2), or

(ii) in the case such a reconsideration or appeal has been taken, the refund is made within 15 days after the date the physician receives notice of an adverse determination on reconsideration or appeal.

(C) Subparagraph (A) shall not apply to the furnishing of a service by a physician to an individual if—

(i) the physician did not know and could not reasonably have been expected to know that payment may not be made for the service by reason of section 1862(a)(1), or

(ii) before the service was provided, the individual was informed that payment under this part may not be made for the specific service and the individual has agreed to pay for that service.

(2) Each carrier with a contract in effect under this section with respect to physicians and each 1 per review organization with a contract under part B of title XI shall send any notice of denial of payment for physicians' services based on section 1862(a)(1) and for which payment is not requested on an assignment-related basis to the physician and the individual involved.

(3) If a physician knowingly and willfully fails to make refunds in violation of paragraph (1)(A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(m)(1) In the case of a nonparticipating physician who—

(A) performs an elective surgical procedure for an individual enrolled for benefits under this part and for which the physician's actual charge is at least \$500, and

(B) does not accept payment for such procedure on an assignment-related basis,

the physician must disclose to the individual, in writing and in a form approved by the Secretary, the physician's estimated actual charge for the procedure, the estimated approved charge under this part for the procedure, and the excess of the physician's actual charge over the approved charge.

(2) A physician who fails to make a disclosure required under paragraph (1) with respect to a procedure shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected for the procedure in excess of the charges recognized and approved under this part.

(3) If a physician knowingly and willfully fails to comply with the paragraph (2), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(4) The Secretary shall provide for such monitoring of requests for payment for physicians' services to which paragraph (1) applies as is necessary to assure compliance with paragraph (2).

* * * * *

PHYSICIAN PAYMENT REVIEW COMMISSION

SEC. 1845. (a)(1) * * *

(2) The Commission shall consist of [11] 13 individuals. Members of the Commission shall first be appointed no later than May 1, 1986, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than four members expire in any one year.

* * * * *

PART C—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f), and 1815(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and subsection (i) of this section) means an institution which—

(1) * * *

* * * * *

(6)(A) has in effect a hospital utilization review plan which meets the requirements of subsection (k) and (B) has in place a discharge planning process that meets the requirements of subsection (ee);

* * * * *

Reasonable Cost

(v)(1)(A) * * *

* * * * *

(R) Such regulations shall provide that costs respecting unsuccessful appeals (as defined by the Secretary) shall not be allowable as reasonable costs.

* * * * *

Discharge Planning Process

(ee)(1) A discharge planning process of a hospital shall be considered sufficient if it is applicable to services furnished by the hospital to individuals entitled to benefits under this title and if it meets

the guidelines and standards established by the Secretary under paragraph (2).

(2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care. The guidelines and standards shall include the following:

(A) The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.

(B) Hospitals must provide a discharge planning evaluation for patients identified under subparagraph (A) and for other patients upon the request of the patient, patient's representative, or patient's physician.

(C) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

(D) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services and the availability of those services.

(E) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).

(F) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

(G) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel.

* * * * *

EFFECT OF ACCREDITATION

SEC. 1865. (a) Except as provided in subsection (b) and the second sentence of section 1863, if—

(1) an institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals, and

(2) such institution (if it is included within a survey described in section 1864(c)) authorizes the Commission to release to the Secretary upon his request (or such State agency as the Secretary may designate) a copy of the most current accreditation survey of such institution made by such Commission, then, such institution shall be deemed to meet the requirements of the numbered paragraphs of section 1861(e); except—

(3) paragraph (6) thereof, and

(4) any standard, promulgated by the Secretary pursuant to paragraph (9) thereof, which is higher than the requirements prescribed for accreditation by such Commission.

If such Commission, as a condition for accreditation of a hospital, requires a utilization review plan (or imposes another requirement

which serves substantially the same purpose), *requires a discharge planning process (or imposes another requirement which serves substantially the same purpose)*, or imposes a standard which the Secretary determines is at least equivalent to the standard promulgated by the Secretary as described in paragraph (4) of this subsection, the Secretary is authorized to find that all institutions so accredited by such Commission comply also with *clause (A) or (B) of section 1861(e)(6) or the standard described in such paragraph (4)*, as the case may be. In addition, if the Secretary finds that accreditation of an entity by the American Osteopathic Association or any other national accreditation body provides reasonable assurance that any or all of the conditions of section 1832(a)(2)(F)(i), 1961(e), 1861(f), 1861(j), 1861(o), 1861(p)(4) (A) or (B), paragraphs (11) and (12) of section 1861(s), section 1861(aa)(2), 1861(cc)(2), or 1861(dd)(2), as the case may be, are met, he may, to the extent he deems it appropriate, treat such entity as meeting the condition or conditions with respect to which he made such finding. The Secretary may not disclose any accreditation survey made and released to him by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association, or any other national accreditation body, of an entity accredited by such body.

* * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) * * *

* * * * *

(F)(i) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b), (c), or (d) of section 1886, to maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a utilization and quality control peer review organization which has a contract with the Secretary under part B of title XI for the area in which the hospital is located, under which the organization will perform functions under that part with respect to the review of the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1886(d)(5), with respect to inpatient hospital services for which payment may be made under part A of this title (and for purposes of payment under this title, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A, and [(i)] (I) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, [(ii)] (II) shall be trans-

ferred from the Federal Hospital Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and [(iii)] (III) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1986 for direct and administrative costs (adjusted for inflation) of such reviews,

(ii) in the case of hospitals, skilled nursing facilities, and home health agencies, to maintain an agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the hospital, facility, or agency is located) to perform the functions described in paragraph (4)(A);

* * * * *

(I) in the case of a hospital, to comply with the requirements of section 1867 to the extent applicable, [and]

(J) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of title 10, or under section 613 of title 38, United States Code, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulation issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of title 10, United States Code[.],

[(I)](K) not to charge any individual or any other person for items or services for which payment under this title is denied under section 1154(a)(2) by reason of a determination under section 1154(a)(1)(B)[.],

(L) in the case of hospitals, to provide to each individual who is entitled to benefits under part A (or to a legally responsible person or persons acting on the individual's behalf), at or about the time of the individual's admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains—

(i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this title,

(ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,

(iii) the individual's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and

(iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal, and which provides such additional information as the Secretary may specify, and

(M) in the case of hospitals—

(i) to make available to its patients the directory or directories of participating physicians (published under section 1942(h)(4)) for the area served by the hospital, and

(ii) if hospital personnel (including (staff of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis, the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one qualified participating physician who is listed in such a directory and from whom the patient may receive the necessary services.

* * * * *

(4)(A) Under the agreement required under paragraph (1)(F)(ii), the peer review organization must perform functions (other than those covered under an agreement under paragraph (1)(F)(i)) under the third sentence of section 1154(a)(4)(A) and under section 1154(a)(14) with respect to services, furnished by the hospital, facility, or agency involved, for which payment may be made under this title.

(B) For purposes of payment under this title, the cost of such an agreement to the hospital, facility, or agency shall be considered a cost incurred by such hospital, facility, or agency in providing covered services under this title and shall be paid directly by the Secretary to the peer review organization on behalf of such hospital, facility, or agency in accordance with a schedule established by the Secretary.

(C) Such payments—

(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(ii) shall not be less in the aggregate for hospitals, facilities, and agencies for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such hospitals, facilities, or agencies under part B of title XI.

* * * * *

EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN ACTIVE LABOR

SEC. 1867. (a) * * *

(e) DEFINITIONS.—In this section:

(1) * * *

(3) The term “participating hospital” means hospital that has entered into a provider agreement under section 1866 [and has, under the agreement, obligated itself to comply with the requirements of this section].

* * * * *

DETERMINATIONS; APPEALS

SEC. 1869. (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of

the amount of benefits under part A, *the amount of benefits with respect to home health services under part B, and any other determination with respect to a claim for benefits under part A* shall be made by the Secretary in accordance with regulations prescribed by him.

(b)(1) Any individual dissatisfied with any determination under subsection (a) as to—

(A) whether he meets the conditions of section 226 of this Act or section 103 of the Social Security Amendments of 1965, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this title or section 1818, [or]

(C) the amount of benefits under part A (including a determination where such amount is determined to be zero), or

(D) *any other denial (other than under part B of title XI) of a claim for benefits under part A or a claim for benefits with respect to home health services under part B,*

shall be entitled to a hearing thereon by the secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). *Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this subsection by a person that furnishes or supplies the individual, directly or indirectly, with services or items solely on the basis that the person furnishes or supplies the individual with such a service or item. Such a person cannot represent a beneficiary with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal.*

* * * * *

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a)(1)(A) The Secretary shall annually determine, and shall [publish] *announce (in a manner intended to provide notice to interested parties)* not later than September 7 before the calendar year concerned—

(i) a per capita rate of payment for each class of individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing contract and who are entitled to benefits under part A and enrolled under part B, and

(ii) a per capita rate of payment for each class of individuals who are so enrolled with such an organization and who are enrolled under part B only.

For purposes of this section, the term "risk-sharing contract" means a contract entered into under subsection (g) and the term "reasonable cost reimbursement contract" means a contract entered into under subsection (h).

* * * * *

(c)(1) * * *

* * * * *

(3)(A) * * *

* * * * *

(E) Each eligible organization shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee's rights under this section, including an explanation of—

- (i) the enrollee's rights to benefits from the organization,*
- (ii) the restrictions on payments under this title for services furnished other than by or through the organization,*
- (iii) out-of-area coverage provided by the organization,*
- (iv) the organization's coverage of emergency services and urgently needed care, and*
- (v) appeal rights of enrollees.*

* * * * *

(f)(1) * * *

(2) The Secretary may modify or waive the requirement imposed by paragraph (1) only [if the Secretary determines that—

[(A) special circumstances warrant such modification or waiver, and

[(B) the eligible organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.] if more than 50 percent of the population of the area served by the organization consists of individuals who are entitled to benefits under this title or under a State plan approved under title XIX.

(3) If the Secretary determines that an eligible organization has failed to comply with the requirements of this subsection, the Secretary may provide for the suspension of enrollment of individuals under this section with the organization after the date the Secretary notifies the organization of such noncompliance.

(g)(1) * * *

* * * * *

(6)(A) A risk-sharing contract under this section shall require the eligible organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for covered services and supplies furnished to individuals enrolled under this section, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

(B) In the case of an eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with subparagraph (A), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individuals enrolled under this section under the contract. If the Secretary provides for such direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this section to reflect the amount of

the Secretary's payments (and his costs incurred in making such payments).

* * * * *

(i)(1) * * *

(3) Each contract under this section—

(A) * * *

* * * * *

(C) (i) shall require the organization to comply with subsections (a) and (c) of section 1318 of the Public Health Service Act relating to disclosure of certain financial information) and with the requirement of section 1301(c)(8) of such Act (relating to liability arrangements to protect members); [and]

(ii) shall require the organization to provide and supply information (described in section 1866(b)(2)(C)(ii)) in the manner such information is required to be provided or supplied under that section;

(iii) shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties; and

* * * * *

(6)(A) Any eligible organization with a risk-sharing contract under this section that fails substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under such contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals, is subject to a civil money penalty of not more than \$2,000 for each such failure.

(B) The provisions of section 1128A (other than subsection (a)) shall apply to a civil money penalty under subparagraph (A) in the same manner as they apply to a civil money penalty under that section.

(7)(A) Each risk-sharing contract with an eligible organization under this section shall provide that the organization will maintain an agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the eligible organization is located) under which the peer review organization will perform functions under section 1154(a)(4)(B) and section 1154(a)(14) (other than those performed under contracts described in section 1866(a)(1)(F)) with respect to services, furnished by the eligible organization, for which payment may be made under this title.

(B) For purposes of payment under this title, the cost of such agreement to the eligible organization shall be considered a cost incurred by a provider of services in providing covered services under this title and shall be paid directly by the Secretary to the peer review organization on behalf of such eligible organization in accordance with a schedule established by the Secretary.

(C) Such payments—

(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Supple-

mentary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(ii) shall not be less in the aggregate for such organizations for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting activities described in subparagraph (A) with respect to such eligible organizations under part B of title XI.

PENALTIES

SEC. 1877. (a) * * *

(b)(1) * * *

* * * * *

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; [and]

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services. [.] and

(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of providers of services if—

(i) the person has a written contract, with each such vendor and each such provider of services, which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage (not to exceed 3 percent) of the value of the purchases made by each such provider under the contract, and

(ii) the person discloses to each such provider the amount received from each such vendor with respect to purchases made by or on behalf of the provider.

* * * * *

LIMITATION ON LIABILITY OF BENEFICIARY WHERE MEDICARE CLAIMS ARE DISALLOWED

SEC. 1879. (a) Where—

(1) a determination is made that, by reason of section 1862(a)(1) or (9) *reason of a coverage denial described in subsection (g)*, payment may not be made under part A or part B of this title for any expenses incurred for items or services furnished an individual by a provider of services or by another person pursuant to an assignment under section 1842(b)(3)(B)(ii), and

(2) both such individual and such provider of services or such other person, as the case may be, did not know, and could not reasonably have been expected to know, that payment would

not be made for such items or services under such part A or part B,

then to the extent permitted by this title, payment shall, notwithstanding such determination, be made for such items or services (and for such period of time as the Secretary finds will carry out the objectives of this title), as though section 1862(a)(1) and section 1862(a)(9) did not apply *and as though the coverage denial described in subsection (g) had not occurred*. In each such case the Secretary shall notify both such individual and such provider of services or such other person, as the case may be, of the conditions under which payment for such items or services was made and in the case of comparable situations arising thereafter with respect to such individual or such provider or such other person, each shall, by reason of such notice (or similar notices provided before the enactment of this section), be deemed to have knowledge that payment cannot be made for such items or services or reasonably comparable items or services. Any provider or other person furnishing items or services for which payment may not be made by reason of section 1862(a) (1) or (9) *or by reason of a coverage denial described in subsection (g)* shall be deemed to have knowledge that payment cannot be made for such items or services if the claim relating to such items or services involves a case, provider or other person furnishing services, procedure, or test, with respect to which such provider or other person has been notified by the Secretary (including notification by a utilization and quality control peer review organization) that a pattern of inappropriate utilization has occurred in the past, and such provider or other person has been allowed a reasonable time to correct such inappropriate utilization.

* * * * *

(c) No payments shall be made under this title in any cases in which the provisions of paragraph (1) of subsection (a) are met, but both the individual to whom the items or services were furnished and the provider of service or other person, as the case may be, who furnished the items or services knew, or could reasonably have been expected to know, that payment could not be made for items or services under part A or part B by reason of section 1862(a)(1) or (a)(9) *or by reason of a coverage denial described in subsection (g)*.

* * * * *

(f)(1)(A) *A skilled nursing facility which meets the applicable requirements of paragraphs (3) and (4) shall be presumed to meet the requirement of subsection (a)(2) with respect to denials of coverage by reason of section 1862(a) (1) or (9).*

(B) *A home health agency which meets the applicable requirements (i) of paragraphs (3) and (4) shall be presumed to meet the requirement of subsection (a)(2) with respect to denials of coverage by reason of section 1862(a) (1) or (9) or (ii) of paragraphs (3) and (5) shall be presumed to meet the requirement of subsection (a)(2) with respect to any coverage denial described in subsection (g).*

(C) *A hospice program which meets the applicable requirements of paragraphs (3) and (4) shall be presumed to meet the requirement of subsection (a)(2) with respect to denials of coverage by reason of section 1862(a) (1) or (9).*

(2) The presumption of paragraph (1) with respect to specific services may be rebutted by actual or imputed knowledge of the facts described in subsection (a)(2), including any of the following:

(A) Notice by the fiscal intermediary of the fact that payment may not be made under this title with respect to the services.

(B) In the case of a skilled nursing facility, the committee or group responsible for the conduct of utilization review for the facility has informed the facility that payment may not be made under this title with respect to the services.

(C) It is clear and obvious that the provider should have known at the time the services were furnished that they were excluded from coverage.

(3) The requirements of this paragraph are as follows:

(A) The facility, agency, or program complies with requirements of the Secretary under this title respecting timely submission of bills for payment and medical documentation.

(B) The facility, agency, or program has reasonable procedures to notify promptly each patient (and the patient's physician) where it is determined that a patient is being or will be furnished items or services which are excluded from coverage under this title.

(4) The requirement of this paragraph is that, on the basis of bills submitted during the previous quarter, the rate of denial of bills by reason of section 1862(a) (1) or (9) for—

(A) a skilled nursing facility does not exceed 5 percent, computed based on days of post-hospital extended care services billed,

(B) a home health agency does not exceed 2.5 percent, computed based on visits for home health services billed, or

(C) for a hospice program does not exceed 2.5 percent, computed based on visits for hospice care billed.

(5) The requirement of this paragraph is that, on the basis of bills submitted by a home health agency during the previous quarter, the rate of denial of bills for the agency by reason of a coverage denial described in subsection (g) does not exceed 2.5 percent, computed based on visits for home health services billed.

(6) The Secretary shall report annually to Congress—

(A) information on the frequency and distribution (by type of provider) of denials referred to in paragraphs (4) and (5), including—

(i) the reasons for such denials,

(ii) the extent to which payments were nonetheless made because of this section, and

(iii) the rate of reversals of such denials, and

(B) such other information as may be appropriate to evaluate the appropriateness of the percentage standards established under paragraphs (4) and (5).

(7) In this subsection, the term "fiscal intermediary" means, with respect to a skilled nursing facility, home health agency, or hospice program, an agency or organization with an agreement under section 1816 with respect to the facility, agency, or program.

(g) The coverage denial described in this subsection is, with respect to the provision of home health services to an individual, a

failure to meet the requirements of section 1814(a)(2)(C) or section 1835(a)(2)(A) in that the individual—

(1) is or was not confined to his home, or

(2) does or did not need skilled nursing care on an intermittent basis or physical, speech, or occupational therapy.

(h) The Secretary shall develop procedures to expedite the determination of whether initial claims submitted for post-hospital extended care services, home health services, and hospice care provided (or to be provided) to an individual may be reimbursed under this title, so as to minimize the time between (1) when the provider first provides the services to the individual, and (2) when the provider first receives notice of an individual determination on whether or not payment may be made under this title for some or all of the services provided the individual.

* * * * *

MEDICARE COVERAGE FOR END STAGE RENAL DISEASE PATIENTS

SEC. 1881. (a) * * *

(b)(1) * * *

* * * * *

(7) The Secretary shall provide by regulation for a method (or methods) for determining prospectively the amounts of payments to be made for dialysis services furnished by providers of services and renal dialysis facilities to individuals in a facility and to such individuals at home. Such method (or methods) shall provide for the prospective determination of a rate (or rates) for each mode of care based on a single composite weighted formula (which takes into account the mix of patients who receive dialysis services at a facility or at home and the relative costs of providing such services in such settings) for hospital-based facilities and such a single composite weighted formula for other renal dialysis facilities, or based on such other method or combination of methods which differentiate between hospital-based facilities and other renal dialysis facilities and which the Secretary determines, after detailed analysis, will more effectively encourage the more efficient delivery of dialysis services and will provide greater incentives for increased use of home dialysis than through the single composite weighted formulas. The Secretary shall provide for such exceptions to such methods as may be warranted by unusual circumstances (including the special circumstances of sole facilities located in isolated, rural areas). *Each application for such an exception for a sole facility located in an isolated, rural area shall be deemed to be approved as of the date of its filing unless the Secretary disapproves it by not later than 45 working days after the date the application is filed.* The Secretary may provide that such method will serve in lieu of any target reimbursement rate that would otherwise be established under paragraph (6). *The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the network administrative organization (designated under subsection (c)(1)(A) for the network area in which the*

treatment is provided) for its necessary and proper administrative costs incurred in carry out its responsibilities under subsection (c)(2).

* * * * *

[(c)(1)(A) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall establish, in accordance with such criteria as he finds appropriate, renal disease network areas, such network organizations (including a coordinating council, an executive committee of such council, and a medical review board, for each network area) as he finds necessary to accomplish such purpose, and a national end stage renal disease medical information system. The Secretary may by regulations provide for such coordination of network planning and quality assurance activities and such exchange of data and information among agencies with responsibilities for health planning and quality assurance activities under Federal law as is consistent with the economical and efficient administration of this section and with the responsibilities established for network organizations under this section.]

(c)(1)(A)(i) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall, in accordance with such criteria as he finds necessary to assure the performance of the responsibilities and functions specified in paragraph (2)—

(I) establish at least 17 end stage renal disease network areas, and

(II) for each such area, designate a network administrative organization which, in accordance with regulations of the Secretary, shall establish (aa) a network council of renal dialysis and transplant facilities located in the area and (bb) a medical review board which has a membership including at least one patient representative and physicians, nurses, and social workers engaged in treatment relating to end stage renal disease.

The Secretary shall publish in the Federal Register a description of the geographic area that he determines, after consultation with appropriate professional and patient organizations, constitutes each network area and the criteria on the basis of which such determination is made.

(ii)(I) In order to determine whether the Secretary should enter into, continue, or terminate an agreement with a network administrative organization designated for an area established under clause (i), the Secretary shall develop and publish in the Federal Register standards, criteria, and procedures to evaluate an applicant organization's capabilities to perform (and, in the case of an organization with which such an agreement is in effect, actual performance of) the responsibilities described in paragraph (2).

(II) An agreement with a network administrative organization may be terminated by the Secretary only if he finds, after applying such standards and criteria, that the organization has failed to perform its prescribed responsibilities effectively and efficiently. If such an agreement is to be terminated, the Secretary shall select a successor to the agreement on the basis of competitive bidding and in a manner that provides an orderly transition.

[(B) At least one patient representative shall serve as a member of each coordinating council and executive committee.]

(B) *At least one patient representative shall serve as a member of each network council and each medical review board.*

* * * * *

(2) The network organizations of each network shall be responsible, in addition to such other duties and functions as may be prescribed by the Secretary, for—

(A) encouraging, consistent with sound medical practice, the use of those treatment settings most compatible with the successful rehabilitation of the patient *and the participation of patients, providers of services, and renal disease facilities in vocational rehabilitation programs;*

(B) developing criteria and standards relating to the quality and appropriateness of patient care; and network goals with respect to the placement of patients in self-care settings and undergoing or preparing for transplantation *and with respect to working with patients, facilities, and providers in encouraging participation in vocational rehabilitation programs;*

* * * * *

(D) *implementing a procedure for evaluating and resolving patient grievances;*

(E) *conducting on-site reviews of facilities and providers as necessary (as determined by a medical review board or the Secretary), utilizing standards of care established by the network organization to assure proper medical care;*

(F) *collecting, validating, and analyzing such data as are necessary to prepare the reports required by subparagraph (H) and subsection (g) and to assure the maintenance of the registry established under paragraph (7);*

[(D)] (G) identifying facilities and providers that are not cooperating toward meeting network goals and assisting such facilities and providers in developing appropriate plans for correction *and reporting to the Secretary on facilities and providers that are not providing appropriate medical care;* and

[(E)] (H) submitting to annual report to the Secretary on July 1 of each year which shall include a full statement of the network's goals, data on the network's performance in meeting its goals (including data on the comparative performance of facilities and providers with respect to the identification and placement of suitable candidates in self-care settings and transplantation *and encouraging participation in vocational rehabilitation programs*), identification of those facilities that have consistently failed to cooperate with network goals, and recommendations with respect to the need for additional or alternative services or facilities in the network in order to meet the network goals, including self-dialysis training, transplantation, and organ procurement facilities.

(3) Where the Secretary determines, on the basis of the data contained in the network's annual report and such other relevant data as may be available to him, that a facility or provider has consistently failed to cooperate with network plans and goals *or to follow*

the recommendations of the medical review board, he may terminate or withhold certification of such facility or provider (for purposes of payment for services furnished to individuals with end stage renal disease) until he determines that such provider or facility is making reasonable and appropriate efforts to cooperate with the network's plans and goals. If the Secretary determines that the facility's or provider's failure to cooperate with network plans and goals does not jeopardize patient health or safety or justify termination of certification, he may instead, after reasonable notice to the provider or facility and to the public, impose such other sanctions as he determines to be appropriate, which sanctions may include denial of reimbursement with respect to some or all patients admitted to the facility after the date of notice to the facility or provider, and graduated reduction in reimbursement for all patients.

* * * * *

(6) It is the intent of the Congress that the maximum practical number of patients who are medically, socially, and psychologically suitable candidates for home dialysis or transplantation should be so treated *and that the maximum practical number of patients who are suitable candidates for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment.* The Secretary shall consult with appropriate professional and network organizations and consider available evidence relating to developments in research, treatment methods, and technology for home dialysis and transplantation. The Secretary shall periodically submit to the Congress such legislative recommendations as the Secretary finds warranted on the basis of such consultation and evidence to further the national objective of maximizing the use of home dialysis and transplantation consistent with good medical practice.

(7) *The Secretary shall establish a national end stage renal disease registry the purpose of which shall be to assemble and analyze the data reported by network organizations, transplant centers, and other sources on all end stage renal disease patients in a manner that will permit—*

(A) the preparation of the annual report to the Congress required under subsection (g);

(B) an identification of the economic impact, cost-effectiveness, and medical efficacy of alternative modalities of treatment;

(C) an evaluation with respect to the most appropriate allocation of resources for the treatment and research into the cause of end stage renal disease;

(D) the determination of patient mortality and morbidity rates, and trends in such rates, and other indices of quality or care; and

(E) such other analyses relating to the treatment and management of end stage renal disease as will assist the Congress in evaluating the end stage renal disease program under this section.

The Secretary shall provide for such coordination of data collection activities, and such consolidation of existing end stage renal disease

data systems, as is necessary to achieve the purpose of such registry, shall determine the appropriate location of the registry, and shall provide for the appointment of a professional advisory group to assist the Secretary in the formulation of policies and procedures relevant to the management of such registry.

* * * * * * *

(f)(1) * * *

* * * * * * *

[(7) The Secretary shall conduct a study of the medical appropriateness and safety of cleaning and reusing dialysis filters by home dialysis patients. In such cases in which the Secretary determines that such home cleaning and reuse of filters is a medically sound procedure, the Secretary shall conduct experiments to evaluate such home cleaning and reuse as a method of reducing the costs of the end stage renal disease program.]

(7)(A) The Secretary shall establish protocols on standards and conditions for the reuse of dialyzer filters for those facilities and providers which voluntarily elect to reuse such filters.

(B) The Secretary shall study and review the appropriateness of establishing protocols on standards and conditions for the reuse (where appropriate) of other dialysis supplies (such as blood lines, transducer filters, and dialyzer caps). If the Secretary determines that the establishment of such a protocol with respect to such a dialysis supply is appropriate, the Secretary may establish such a protocol.

(C) The Secretary shall incorporate protocols established under this paragraph into the requirements for facilities prescribed under subsection (b)(1)(A) and failure to follow such a protocol subjects such a facility to denial of participation in the program established under this section and to denial of payment for dialysis treatment not furnished in compliance with such a protocol.

* * * * * * *

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a)(1)(A) * * *

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(b)(1) * * *

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(3)(A) * * *

(B)(i) For purposes of subparagraph (A) for 12-month cost reporting periods beginning during a fiscal year and for purposes of subsection (d) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—

(I) for fiscal year 1986, $\frac{1}{2}$ percent,

[(II) for fiscal years 1987 and 1988, a percentage determined by the Secretary pursuant to subsection (e)(4), but not to exceed the market basket percentage increase (as defined in clause (ii)), and]

(II) for fiscal year 1987, 1.3 percent, and for fiscal year 1988, the market basket percentage increase (as defined in clause (ii)) minus 2.0 percentage points, and

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(d)(1) * * *

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(2)(A) * * *

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(C) STANDARDIZING AMOUNTS.—The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—

(i) excluding an estimate of indirect medical education costs [(taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985)],

(ii) adjusting for variations among hospitals by area in the average hospital wage level, and

(iii) adjusting for variations in case mix among hospitals[, and].

[(iv) for discharges occurring on or after October 1, 1986, and before October 1, 1988, excluding an estimate of the additional payments to certain hospitals to be made under paragraph (5)(F).]

* * * * *

(3) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in a fiscal year after fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region for which payment may be made under part A of this title. Each such rate shall be determined for hospitals located in urban or rural areas within the United States and within each such region, respectively, as follows:

(A) UPDATING PREVIOUS STANDARDIZED AMOUNTS.—The Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph, increased for each of fiscal years 1985 [and 1986], 1986, 1987, and 1988 by the applicable percentage increase under subsection (b)(3)(B), and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4), and adjusted to reflect the most recent case-mix data available. *If the formula under paragraph (5)(B) for determining payments for the indirect costs of medical education is changed for any fiscal year, the Secretary shall readjust the standardized amounts pre-*

viously determined for each hospital to take into account the changes in that formula.

* * * * *

(C)(i) * * *

[(ii) REDUCING FOR SAVINGS FROM AMENDMENT TO INDIRECT TEACHING ADJUSTMENT FOR DISCHARGES AFTER SEPTEMBER 30, 1986.—For discharges occurring after September 30, 1986, the Secretary shall further reduce each of the average standardized amounts (in a proportion which takes into account the differing effects of the standardization effected under paragraph (2)(C)(i)) so as to provide for a reduction in the total of the payments (attributable to this paragraph) made for discharges occurring—

[(I) on or after October 1, 1986, and before October 1, 1988, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985 if the factor described in clause (ii)(II) of paragraph (5)(B) were applied for discharges occurring during such period instead of the factor described in clause (ii)(I) of that paragraph, and

[(II) on or after October 1, 1988, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) for those discharges that has resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985.]

(ii) REDUCING FOR SAVINGS FROM AMENDMENT TO INDIRECT TEACHING ADJUSTMENT FOR DISCHARGES AFTER SEPTEMBER 30, 1986.—*The Secretary shall further reduce each of the average standardized amounts by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which is the difference between (I) the sum of the additional payment amounts under paragraph (5)(B) (relating to indirect costs of medical education) if the indirect teaching adjustment factor were equal to 1.159r (as "r" is defined in paragraph (5)(B)(ii)) and (II) that sum using the factor specified in paragraph (5)(B)(ii)(II).*

(iii) REDUCING FOR DISPROPORTIONATE SHARE PAYMENTS.—*The Secretary shall further reduce each of the average standardized amounts by reducing the standardized amount for each hospital (as previously determined without regard to this clause) by a proportion equal to the proportion (established by the Secretary) of the amount of payment under this subsection based on DRG prospective payment amounts which are additional payments described in paragraph (5)(F) (relating to disproportionate share payments) for subsection (d) hospitals.*

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(5)(A) * * *

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(C)(i) The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection (*other than under paragraph (9)*) as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas). A hospital which is classified as a rural hospital may appeal to the Secretary to be classified as a rural referral center under this clause on the basis of criteria (established by the Secretary) which shall allow the hospital to demonstrate that it should be so reclassified by reason of certain of its operating characteristics being similar to those of a typical urban hospital located in the same census region and which shall not require a rural osteopathic hospital to have more than 3,000 discharges in a year in order to be classified as a rural referral center.

Such characteristics may include wages, scope of services, service area, and the mix of medical specialties. The Secretary shall publish the criteria not later than August 17, 1984, for implementation by October 1, 1984. An appeal allowed under this clause must be submitted to the Secretary (in such form and manner as the Secretary may prescribe) during the quarter before the first quarter of the hospital's cost reporting period (or, in the case of a cost reporting period beginning during October 1984, during the first quarter of that period), and the Secretary must make a final determination with respect to such appeal within 60 days after the date the appeal was submitted. Any payment adjustments necessitated by a reclassification based upon the appeal shall be effective at the beginning of such cost reporting period.

(ii) With respect to a subsection (d) hospital which is a "sole community hospital", payment under paragraph (1)(A) for any cost reporting period or fiscal year beginning on or after October 1, 1984, shall be determined under the formula provided in clause (i) of that paragraph with the target and DRG percentages determined under paragraph (1)(C)(i) (except that any reference to paragraph (2) shall be deemed, for this purpose, a reference to paragraph (3)). In the case of a sole community hospital that experiences, in a cost reporting period (beginning on or after October 1, 1983, and before October 1, 1986) compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (*other than under paragraph (9)*) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services. In the case of a sole community hospital which experiences, in any cost reporting period after the cost reporting period which was used as the base for determining the target amount for payments to such hospital under paragraph (1)(A)(i)(I), a significant increase in operating costs attributable to the addition of new inpatient facilities or services at such hospital (including the opening of a special care unit), the Secretary shall provide for such adjustment to the payment amounts under this subsection (*other than under paragraph (9)*) for such cost reporting period and subsequent cost reporting periods as may be necessary to reasonably compensate

such hospital for such increased costs. For purposes of this subparagraph, the term "sole community hospital" means a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographical area who are entitled to benefits under part A.

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(F)(i) * * *

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(vi) In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—

(I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this title and were entitled to **[supplementary]** *supplemental* security income benefits (excluding any State supplementation) under title XVI of this Act, and the denominator of which is the number of such hospital's patient days for such **[fiscal year]** *period* which were made up of patients who (for such days) were entitled to benefits under part A of this title, and

* * * * *

(7) There shall be no administrative or judicial review under section 1878 or otherwise of—

(A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1), **[and]**

(B) the establishment of diagnosis-related groups, of the methodology for the classification of discharges within such groups, and of the appropriate weighting factors thereof under paragraph (4)**[.]**, and

(C) *the determination of a capital reduction percentage under subsection (g)(3).*

* * * * *

(9)(A) *Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges in a fiscal year beginning on or after October 1, 1986, is equal to the sum of—*

(i) 75 percent of the Puerto Rico adjusted DRG prospective payment rate (determined under subparagraph (B) or (C)) for such discharges, and

(ii) 25 percent of the average of—

(I) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in an urban areas, and

(II) such rate for hospitals located in a rural areas, for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels.

As used in this section, the term "subsection (d) Puerto Rico hospital" means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the fifty States.

(B) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1987 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for such hospitals located in urban or rural areas within Puerto Rico, as follows:

(i) The Secretary shall determine the target amount (as defined in subsection (b)(3)(A) for the hospital for the cost reporting period beginning in fiscal year 1986 and increase such amount by the applicable percentage increase (as defined in subsection (b)(3)(B)) for fiscal year 1987.

(ii) The Secretary shall standardize the amount determined under clause (i) for each hospital by—

(I) excluding an estimate of indirect medical education costs,

(II) adjusting for variations among hospitals by area in the average hospital wage level, and

(III) adjusting for variations in case mix among hospitals.

(iii) The Secretary shall compute an average of the standardized amounts determined under clause (ii) for all hospitals located in an urban area and for all hospitals located in a rural area (as such terms are defined in paragraph (2)(D)).

(iv) The Secretary shall reduce the average standardized amount by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments) or in subparagraph (D)(v) (relating to disproportionate share payments) for subsection (d) Puerto Rico hospitals.

(v) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

(I) the average standardized amount (computed under clause (iii) and reduced under clause (iv)) for hospitals located in an urban or rural area, respectively, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(vi) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (v) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level.

(C) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge after fiscal year 1987 involving inpatient hospital services of a subsection

(d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for hospitals located in urban or rural areas within Puerto Rico as follows:

(i) The Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area equal to the respective average standardized amount computed for the previous fiscal year under subparagraph (B)(iii) or under this clause, increased for fiscal year 1988 by the applicable percentage increase under subsection (b)(3)(B), and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4), and adjusted to reflect the most recent case-mix data available..

(ii) The Secretary shall reduce each of the average standardized amounts by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments) or in subparagraph (D)(v) (relating to disproportionate share payments) for subsection (d) Puerto Rico hospitals.

(iii) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

(I) the average standardized amount (computed under clause (i) and reduced under clause (ii)) for hospitals located in an urban or rural area, respectively, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(iv) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (iii) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level.

(D) The following provisions of paragraph (5) shall apply to subsection (d) Puerto Rico hospitals receiving payment under this paragraph in the same manner and to the extent as they apply to subsection (d) hospitals receiving payment under this subsection:

(i) Subparagraph (A) (relating to outlier payments), except that the total amount of additional payments made under this clause in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected as estimated to be made under this paragraph for discharges in that year.

(ii) Subparagraph (B) (relating to payments for indirect medical education costs), except that for this purpose the sum of the amount determined under subparagraph (A) of this paragraph and the amount paid to the hospital under clause (i) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(B)(i)(I).

(iii) Subparagraph (C)(iii) (relating to exceptions and adjustments).

(iv) *Subparagraph (E) (relating to payments for costs of certified registered nurse anesthetists).*

(v) *Subparagraph (F) (relating to disproportionate share payments), except that for this purpose the sum described in clause (ii) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(F)(ii)(I).*

(e)(1) * * *

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(4) Taking into consideration the recommendations of the Commission, the Secretary shall **[determine for each fiscal year (beginning with fiscal year 1987)]** *recommend for fiscal year 1988 an appropriate change factor for inpatient hospital services for discharges in that fiscal year and shall determine for each subsequent fiscal year the percentage change which will apply for purposes of this section as the applicable percentage increase (otherwise described in subsection (b)(3)(B)) for discharges in that fiscal year, and which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality and shall determine for each fiscal year the capital reduction percentage which should be effected under subsection (g)(3) for that fiscal year. The percentage change for subsection (d) hospitals and subsection (d) Puerto Rico hospitals may be different from that for other hospitals and may vary among such other hospitals.*

(5) The Secretary shall cause to have published in the Federal Register, not later than—

(A) the **[June 1 before each fiscal year (beginning with fiscal year 1986)]** *April 1 before fiscal year 1988 and the June 1 before each subsequent fiscal year, the Secretary's proposed recommendation or determination under paragraph (4) for that fiscal year for public comment, and*

(B) the September 1 before such fiscal year after such consideration of public comment on the proposal as is feasible in the time available, the Secretary's final *recommendation or determination under such paragraph for that year.*

The Secretary shall include in the publication referred to in subparagraph (A) for a fiscal year the report of the Commission's recommendations submitted under paragraph (3) for that fiscal year.

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(g)(1) * * *

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(3)(A) *Notwithstanding section 1861(v)(1), in determining the amount of the hospital capital payments (as defined in subparagraph (D)), the Secretary shall provide for a reduction by such percentage (in this section referred to as the "capital reduction percentage") in such payments as is necessary to provide that the aggregate amount of hospital capital payments attributable to portions of hospital cost reporting periods occurring in fiscal year 1987, in fiscal year 1988, and in fiscal year 1989, does not exceed 110 percent, 120 percent, and 130 percent, respectively, of the aggregate amount of such payments attributable to portions of hospital cost reporting periods occurring in fiscal year 1986, adjusted in accordance with subparagraph (C).*

(B) *The Secretary shall determine the capital reduction percentage based upon the best information available before the beginning of the fiscal year involved and interim and final payments shall be made on the basis of such percentage. Such percentage shall not be subject to change after the date it is promulgated in final form.*

(C) *In computing the hospital capital payments attributable to portions of cost reporting periods occurring in fiscal year 1986 in the computing the limitation on hospital capital payments under subparagraph (A) attributable to portions of cost reporting periods occurring in—*

(i) fiscal year 1987, there shall be excluded 25 percent,

(ii) fiscal year 1988, there shall be excluded 50 percent,

(iii) fiscal year 1989, there shall be excluded 75 percent,

of the amount of the hospital capital payments (attributable to portions of cost reporting periods occurring in fiscal year 1986) that are attributable to a return on equity capital.

(D) *In this paragraph, the term "hospital capital payments" means the payments that may be made under part A of this title with respect to the allowable capital-related costs (as defined by the Secretary) of inpatient hospital services for subsection (d) hospitals and subsection (d) Puerto Rico hospitals.*

(h) **PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—**

(1) * * *

* * * * *

(4) **DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—**

(A) * * *

* * * * *

(E) **FOREIGN MEDICAL GRADUATES REQUIRED TO PASS FMGEMS EXAMINATION.—**

(i) * * *

(ii) **TRANSITION FOR CURRENT FMGS.—**On or after July 1, 1986, but before July 1, 1987, in the case of a foreign medical graduate who—

(I) has served as a resident before July 1, 1986, and is serving as a resident after that date, but

(II) has not passed the FMGEMS examination or a previous examination of the Educational Commission for Foreign Medical Graduates before July 1, 1986.

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

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PAYMENT TO SKILLED NURSING FACILITIES FOR ROUTINE SERVICES COSTS

SEC. 1888. (a) * * *

* * * * *

(d)(1) Any skilled nursing facility may choose to be paid under this subsection on the basis of a prospective payment for all rou-

tine service costs (and capital-related costs) of extended care services provided in a [fiscal year] *cost reporting period* if such facility had, in the preceding [fiscal year] *cost reporting period*, fewer than 1,500 patient days with respect to which payments were made under this title. Such prospective payment shall be in lieu of payments which would otherwise be made for routine service costs pursuant to section 1861(v) and subsections (a) through (c) of this section and capital-related costs pursuant to section 1861(v). This subsection shall not apply to a facility for any [fiscal year] *cost reporting period*, immediately following a [fiscal year] *cost reporting period*, in which such facility had 1,500 or more patient days with respect to which payments were made under this title, without regard to whether payments were made under this subsection during such preceding [fiscal year] *cost reporting period*.

* * * * *

(4) The Secretary shall establish the prospective payment amounts for [each fiscal year] *cost reporting periods beginning in a fiscal year* at least 90 days prior to the beginning of such fiscal year, on the basis of the most recent date available for a 12-month period. A skilled nursing facility must notify the Secretary of its intention to be paid pursuant to this subsection for a [fiscal year] within 60 days after the Secretary establishes the final prospective payment amounts for such fiscal year] *cost reporting period no later than 30 days before the beginning of that period*.

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CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

TITLE IX—MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS

* * * * *

SUBTITLE A—MEDICARE

PART 1—PROVISIONS RELATING TO PART A OF MEDICARE

* * * * *

Subpart B—Miscellaneous Provisions

* * * * *

SEC. 9126. ACCESS TO SKILLED NURSING FACILITIES.

(a) * * *

[(c) REINSTATEMENT OF WAIVER OF LIABILITY PRESUMPTION.—The Secretary of Health and Human Services shall, for purposes of determining whether payments to a skilled nursing facility should be denied pursuant to section 1862(a)(1)(A) of the Social Security Act, apply the same presumption of compliance (5 percent) as in effect under regulations as of July 1, 1985. Such presumption shall apply for the 30-month period beginning with the first month beginning after the date of the enactment of this Act.]

(d) **EFFECTIVE DATES.**—(1) The amendment made by subsection (a) shall apply to **[fiscal years]** *cost reporting periods* beginning on or after October 1, 1986.

* * * * *

SEC. 9127. ADDITIONAL MEMBERS OF PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.

(a) * * *

(b) **APPOINTMENTS.**—The Director of the Congressional Office of Technology Assessment shall appoint the two additional members of the Prospective Payment Assessment Commission, as required by the amendment made by subsection (a), no later than 60 days after the date of the enactment of this Act, for terms of three years, *except that the Director may provide initially for such terms as will insure that (on a continuing basis) the terms of no more than eight members will expire in any one year.*

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PART 2—PROVISIONS RELATING TO PARTS A AND B OF MEDICARE

Subpart A—Payment-Related Provisions

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SEC. 9202. PAYMENTS TO HOSPITALS FOR DIRECT COSTS OF MEDICAL EDUCATION.

(a) * * *

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(j) **SPECIAL TREATMENT OF STATES FORMERLY UNDER WAIVER.**—In the case of a hospital in a State that has had a waiver approved under section 1886(c) of the Social Security Act or *section 402 of the Social Security Amendments of 1967*, for cost reporting periods beginning on or after January 1, 1986, if the waiver is terminated—

(1) the Secretary of Health and Human Services shall permit the hospital to change the method by which it allocates administrative and general costs to the direct medical education cost centers to the method specified in the medicare cost report;

(2) the Secretary may make appropriate adjustments in the regional adjusted DRG prospective payment rate (for the region in which the State is located), based on the assumption that all teaching hospitals in the State use the medicare cost report; and

(3) the Secretary shall adjust the hospital-specific portion of payment under section 1886(d) of such Act for any such hospital that actually chooses to use the medicare cost report.

The Secretary shall implement this subsection based on the best available data.

* * * * *

[SEC. 9205. HOME HEALTH WAIVER OF LIABILITY.

[The Secretary of Health and Human Services shall, for purposes of determining whether payments to a home health agency should be denied pursuant to section 1862(a)(1)(A) of the Social Security Act, apply a presumption of compliance (2.5 percent) in the

same manner as under the regulations in effect as of July 1, 1985. Such presumption shall apply until 12 months after the date on which ten regional intermediaries have commenced operations to service home health agencies, as required under section 1816(e)(4) of the Social Security Act.】

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Subpart B—Other Provisions

* * * * *

SEC. 9221. CONTINUATION OF “ACCESS: MEDICARE” DEMONSTRATION PROJECT.

(a) APPROVAL OF APPLICATION.—The Secretary of Health and Human Services shall approve any application for a waiver of any requirement of titles XVIII and XIX of the Social Security Act necessary to provide for the continuation, through 【September 30, 1986】 *July 31, 1987*, of the “Access: Medicare” demonstration project carried out pursuant to section 222 of the Social Security Amendments of 1972 and section 402(a) of the Social Security Amendments of 1967 by Monroe County Long Term Care Program, Inc.

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PARTS 3—PROVISIONS RELATING TO PART B OF MEDICARE

Subpart A—Payment-Related Provisions

SEC. 9301. MEDICARE PHYSICIAN PAYMENT PROVISIONS.

(a) * * *

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(c) INCENTIVES FOR PARTICIPATING PHYSICIAN PROGRAM.—

(1) * * *

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(5) EFFECTIVE DATE.—Section 【1842(b)(7)】 *1842(h)(7)* of the Social Security Act, as added by paragraph (4) of this subsection, shall apply to explanations of benefits provided on or after such date (not later than October 1, 1986) as the Secretary of Health and Human Services shall specify.

* * * * *

SECTION 603 OF THE SOCIAL SECURITY AMENDMENTS OF 1983

REPORTS, EXPERIMENTS, AND DEMONSTRATION PROJECTS

SEC. 603. (a)(1) * * *

(2)(A) The Secretary shall study and report annually to the Congress at the end of each year (beginning with 1984 and ending with 【1987】 *1989* on the impact of the payment methodology under section 1886(d) of the Social Security Act during the previous year, on classes of hospitals, beneficiaries, and other payors for inpatient hospital services, and other providers, and, in particular, on the

impact of computing DRG prospective payment rates by census division, rather than exclusively on a national basis. Each such report shall include such recommendations for such changes in legislation as the Secretary deems appropriate.

* * * * *

(E) In each annual report to Congress under subparagraph (A), the Secretary shall include—

(i) an evaluation of the adequacy of the procedures for assuring quality of post-hospital services furnished under title XVIII of the Social Security Act,

(ii) an assessment of problems that have prevented groups of medicare beneficiaries (including those eligible for medical assistance under title XIX of such Act) from receiving appropriate post-hospital services covered under such title, and

(iii) information on reconsiderations and appeals taken under title XVIII of such Act with respect to payment for post-hospital services.

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DEFICIT REDUCTION ACT OF 1984

TITLE II—CIVIL SERVICE AND MILITARY RETIREMENT PROGRAMS

* * * * *

SUBTITLE A—MEDICARE AMENDMENTS

PART I—REIMBURSEMENT AND BENEFIT CHANGES

* * * * *

PAYMENT FOR SERVICES OF A NURSE ANESTHETIST

SEC. 2312. (a) * * *

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(c) The amendments made by subsections (a) and (b) shall apply to cost reporting periods beginning on or after October 1, 1984, and before October 1, [1987.] 1988.

* * * * *

CONTRACTS FOR MEDICARE CLAIMS PROCESSING

SEC. 2326. (a) During each [of the fiscal years 1985 and 1986,] fiscal year (beginning with fiscal year 1985 and ending with fiscal year 1989), the Secretary of Health and Human Services may enter into not more than two agreements under section 1816 of the Social Security Act, and not more than two contracts under section 1842 of such Act, on the basis of competitive bidding, or fixed price, without regard to the nominating process under section 1816(a) of such Act during the term of the agreement. Such procedure may be used only for the purpose of replacing an agency or organization or carrier which over a period of time has been in the lowest 20th per-

centile of agencies and organizations or carriers having agreements or contracts under the respective section, as measured by the Secretary's cost and performance criteria. Any agency or organization or carrier selected on the basis of competitive bidding or *fixed price* must perform all of the duties listed in section 1816(a)(1) of such Act, or the duties listed in paragraphs (1) through (4) of section 1842(a) of such Act, as the case may be, and must be a health insuring organization (as determined by the Secretary).

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Internal Revenue Code of 1954

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CHAPTER 1—NORMAL TAXES AND SURTAXES

* * * * *

Subchapter B—Computation of Taxable Income

* * * * *

PART VI—ITEMIZED DEDUCTIONS FOR INDIVIDUALS AND CORPORATIONS

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SEC. 162. TRADE OR BUSINESS EXPENSES.

(a) IN GENERAL.—* * *

* * * * *

(k) CONTINUATION COVERAGE REQUIREMENTS OF GROUP HEALTH PLANS.—

(1) IN GENERAL.—For purposes of subsection (i)(2) and section 106(b)(1), a group health plan meets the requirements of this subsection only if each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled to elect, within the election period, continuation coverage under the plan.

(2) CONTINUATION COVERAGE.—For purposes of paragraph (1), the term "continuation coverage" means coverage under the plan which meets the following requirements:

(A) TYPE OF BENEFIT COVERAGE.—The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred. *If coverage is modified under the plan for similarly situated beneficiaries, such coverage shall also be modified in the same manner for all qualified beneficiaries covered under the plan.*

(B) PERIOD OF COVERAGE.—The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

(i) **MAXIMUM PERIOD.**—In the case of—

(I) a qualifying event described in paragraph (3)(B) (relating to terminations and reduced hours), the date which is 18 months after the date of the qualifying even, **[and]**

(II) *a qualifying event described in paragraph (3)(F) (relating to bankruptcy proceedings), the date of the death of the covered employee or qualified beneficiary (described in paragraph (7)(B)(iii)(III)), or in the case of the surviving spouse or dependent children of the covered employee, 36 months after the date of the death of the covered employee, and*

[(II)] (III) any qualifying event not described in subclause **[(I)]** (I) or (II), the date which is 36 months after the date of the qualifying even **[.]**; *except that in the case of a qualified beneficiary with respect to whom more than one qualifying event occurs, the date may be extended under this clause but in no case may the coverage period with respect to such events (other than the period applicable to a qualifying event described in paragraph (3)(F)) exceed a 36-month period for such qualified beneficiary.*

(ii) **END OF PLAN.**—The date on which the employer ceases to provide any group health plan to any employee.

(iii) **FAILURE TO PAY PREMIUM.**—The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary. *Payment shall be considered to be timely if made within 30 days of the date due or within such longer period as applies to or under the plan.*

(iv) **REEMPLOYMENT OR MEDICARE ELIGIBILITY.**—The date on which the qualified beneficiary first becomes, after the date of the election—

(I) a covered employee under any other group health plan, or

(II) *in the case of a qualified beneficiary other than a qualified beneficiary described in paragraph (7)(B)(iii), entitled to benefits under title XVIII of the the Social Security Act.*

* * * * *

(3) **QUALIFYING EVENT.**—For purposes of this subsection, the term “qualifying event” means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this subsection, would result in the loss of coverage of a qualified beneficiary:

(A) The death of the covered employee.

(B) The termination (other than by reason of such employee’s gross misconduct), or reduction of hours, of the covered employee’s employment.

(C) The divorce or legal separation of the covered employee from the employee’s spouse.

(D) The covered employee becoming entitled to benefits under title XVIII of the the Social Security Act.

(E) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

(F) *A proceeding in a case under title 11, United States Code, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.*

In the case of an event described in subparagraph (F), a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary described in paragraph (7)(B)(iii) within one year before or after the date of commencement of the proceeding.

* * * * *

(5) ELECTION.—For purposes of this subsection—

(A) ELECTION PERIOD.—The term “election period” means the period which—

(i) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event.

(ii) is of at least 60 days’ duration, and

(iii) ends not earlier than 60 days after the later of—

(I) the date described in clause (i), or

(II) in the case of any qualified beneficiary who receives notice under paragraph (6)(D), the date of such notice.

(B) EFFECT OF ELECTION ON OTHER BENEFICIARIES.—Except as otherwise specified in an election, any election by a qualified beneficiary described in clause (i)(I) or (ii) of paragraph (7)(B) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event.

(c) RIGHT TO INDIVIDUAL ELECTION.—*Notwithstanding subparagraph (B), each qualified beneficiary is entitled to make a separate election with respect to continuation coverage for that beneficiary and, if there is a choice of type of coverage under the plan, to make a separate selection among such types of coverage.*

* * * * *

(6) NOTICE REQUIREMENTS.—In accordance with regulations prescribed by the Secretary—

(A) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection.

(B) the employer of an employee under a plan must notify the plan administrator of a qualifying event described in subparagraph (A), (B), or (D) of paragraph (3) with respect to such employee within 30 days of the date of qualifying event.

(C) each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of any qualifying event described in subparagraph (C) of (E) of paragraph (3) *within 60 days of the date of the qualifying event and*

* * * *

(7) DEFINITIONS.—For purposes of this subsection—

(A) COVERED EMPLOYEE.—The term “covered employee” means an individual who is (or was) provided coverage under a group health plan by virtue of the individual’s employment or previous employment with an employer.

(B) QUALIFIED BENEFICIARY—

(i) * * *

* * * *

(iii) SPECIAL RULE FOR RETIREES AND WIDOMS.—*In the case of a qualifying event described in paragraph (3)(F), the term “qualified beneficiary” includes a covered employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such qualifying event, is a beneficiary under the plan—*

(I) as the spouse of the covered employee,

(II) as the dependent child of the employee, or

(III) as the surviving spouse of the covered employee.

* * * *

Subtitle C—Employment Taxes and Collection of Income Tax at Source

* * * *

CHAPTER 21—FEDERAL INSURANCE CONTRIBUTIONS ACT

* * * *

Subchapter C—General Provisions

* * * *

SEC. 3121. DEFINITIONS.

(a) * * *

* * * *

(u) APPLICATION OF HOSPITAL INSURANCE TAX TO FEDERAL, STATE, AND LOCAL EMPLOYMENT.—

(1) FEDERAL EMPLOYMENT.—For purposes of the taxes imposed by sections 3101(b) and 3111(b) subsection (b) shall be applied without regard to paragraph (5) thereof.

(2) STATE AND LOCAL EMPLOYMENT.—For purposes of the taxes imposed by sections 3101(b) and 3111(b)—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), subsection (b) shall be applied without regard to paragraph (7) thereof.

(B) **EXCEPTION FOR CERTAIN SERVICES.**—Service shall not be treated as employment by reason of subparagraph (A) if—

(i) the services is included under an agreement under section 218 of the Social Security Act, or

(ii) the service is performed—

(I) by an individual who is employed by a State or political subdivision thereof to relieve him from unemployment,

(II) in a hospital, home, or other institution by a patient or inmate thereof as an employee of a State or political subdivision thereof or of the District of Columbia,

(III) by an individual, as an employee of a State or political subdivision thereof or of the District of Columbia, serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency, [or]

(IV) by an individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or a medical or dental resident in training[.], or

(V) by an election official or election worker if the remuneration paid in a calendar year for such service is less than \$100.

* * * * *

Subtitle D—Miscellaneous Excise Taxes

Chapter 31. Retail excise taxes.

Chapter 32. Manufacturers excise taxes.

Chapter 33. Facilities and services.

Chapter 34. Policies issued by foreign insurers.

Chapter 35. Taxes on wagering.

Chapter 36. Certain other excise taxes.

Chapter 37. Sugar.

Chapter 39. Registration-required obligations.

Chapter 40. General provisions relating to occupational taxes.

[Chapter 41. Public charities.]

Chapter 41. *Public charities; large employers not members of qualified State health insurance pools*".

Chapter 42. Private foundations, black lung benefit trusts.

Chapter 43. Qualified pension, etc., plans.

Chapter 44. Real estate investment trusts.

Chapter 45. Windfall profit tax on domestic crude oil.

* * * * *

CHAPTER 41—PUBLIC CHARITIES

CHAPTER 41—PUBLIC CHARITIES; LARGE EMPLOYERS NOT MEMBERS OF QUALIFIED STATE HEALTH INSURANCE POOLS

Subchapter A. *Public charities.*

Subchapter B. *Large employers not members of qualified State health insurance pools.*

Subchapter A—Public Charities

* * * * *

Subchapter B—Large Employers Not Members of Qualified State Health Insurance Pools

Sec. 4912. Tax on wages of large employers not members of qualified State health insurance pools.

SEC. 4912. TAX ON WAGES OF LARGE EMPLOYERS NOT MEMBERS OF QUALIFIED STATE HEALTH INSURANCE POOLS.

(a) **TAX IMPOSED.**—*In the case of a large employer which—*

(1) *employs any individual to perform services in a State that has established a qualified health insurance pool, and*

(2) *is not a participating member of that pool in a taxable year at anytime at which such services are performed,*
there is hereby imposed a tax equal to 5 percent of the wages paid by the employer during the taxable year for services performed in the State by its employees.

(b) **LARGE EMPLOYER.**—*For purposes of this section—*

(1) **IN GENERAL.**—*Except as provided in paragraph (2), the term “large employer” means an employer who, on each of some 20 days during the taxable year or the preceding taxable year, each day being in a different calendar week, employed for some portion of the day (whether or not at the same moment of time) 20 or more individuals.*

(2) **EXCEPTION FOR GOVERNMENTAL UNITS.**—*The term “large employer” shall not include the United States, any State or political subdivision thereof, or any possession of the United States or any agency or instrumentality of any of the foregoing (including the United States Postal Service and Postal Rate Commission); except that such term shall include any nonappropriated fund instrumentality of the United States.*

(c) **QUALIFIED HEALTH INSURANCE POOL.**—*For purposes of this section, the term “qualified health insurance pool” means any organization which—*

(1) *is a nonprofit corporation established pursuant to and regulated by State law;*

(2) *permits any large employer doing business in the State to be a participating members;*

(3) *makes available (without regard to health conditions) to all residents of the State, who are not eligible for benefits under part A of title XVIII of the Social Security Act, levels of health insurance typical of the levels of coverage provided through large employer groups, except that—*

(A) *any such level of insurance must limit the amount of the annual out-of-pocket expenses for covered services under individual coverage to \$1,500 and under family coverage to \$3,000,*

(B) *any such level of insurance may not establish a lifetime benefit limit for any individual of less than \$500,000,*

(C) *subject to subparagraph (A), such insurance may provide for a choice of deductibles (in addition to the deductibles typical of levels of coverage provided through large em-*

ployer groups), but not to exceed \$1,000 for each covered individual,

(D) such insurance may deny coverage for covered services for preexisting conditions for a period not to exceed 6 months, and

(E) such insurance must include as covered services the purchase and repair of medically necessary durable medical equipment;

(4) charges a pool premium rate expected to be self-supporting based upon a reasonable actuarial determination of anticipated experience and expected expenses, such pool premium rate in no event to exceed 150 percent of average premium rates for individual standard risks in the State for comparable coverage; and

(5) assesses losses of the pool equitably among all participating members.

Nothing in this subsection shall be construed as preventing a State or other entity from providing for payment of part or all of the premium of an enrollee and from varying the amount of such payment based on the enrollee's income or other basis.

(d) OTHER DEFINITIONS.—

(1) USE OF FUTA DEFINITIONS.—For purposes of this section, the terms “wages”, “employee”, and “employer” have the meanings given such terms in subsections (a), (c), and (d), respectively, of section 3401.

(2) STATE.—The term “State” includes the District of Columbia and the Commonwealth of Puerto Rico.

(e) CROSS REFERENCE.—

(1) For provision denying deduction for tax imposed by this section, see section 275(a)(6).

(2) For provisions making deficiency procedures applicable to tax imposed by this section, see section 6211 et seq.

Subtitle F—Procedure and Administration

* * * * *

CHAPTER 61—INFORMATION AND RETURNS

* * * * *

Subchapter B—Miscellaneous Provisions

* * * * *

SEC. 6104. PUBLICITY OF INFORMATION REQUIRED FROM CERTAIN EXEMPT ORGANIZATIONS AND CERTAIN TRUSTS.

(a) INSPECTION OF APPLICATIONS FOR TAX EXEMPTION.—

* * * * *

(c) PUBLICATION TO STATE OFFICIALS.—

(1) GENERAL RULE.—In the case of any organization which is described in section 501(c)(3) and exempt from taxation under section 501(a), or has applied under section 508(a) for recognition as an organization described in section 501(c)(3), the Secretary at such times and in such manner as he may by regulations prescribe shall—

(A) notify the appropriate State officer of a refusal to recognize such organization as an organization described in section 501(c)(3), or of the operation of such organization in a manner which does not meet, or no longer meets, the requirements of its exemption,

(B) notify the appropriate State officer of the mailing of a notice of deficiency of tax imposed under section 507 [or chapter 41 or 42], *subchapter A of chapter 41 or chapter 42*, and

(C) at the request of such appropriate State officer, make available for inspection and copying such returns, filed statements, records, and other information, relating to a determination under subparagraph (A) or (B) as are relevant to any determination under State law.

(2) APPROPRIATE STATE OFFICER.—For purposes of this subsection, the term “appropriate State officer” means the State attorney general, State tax officer, or any State official charged with overseeing organizations of the type described in section 501(c)(3).

* * * * *

SECTION 114 OF THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 114. (a) * * *

* * * * *

(c)(1) * * *

(2)(A) * * *

* * * * *

(E) The preceding provisions of this paragraph shall not to apply to payments made for current, nonrisk medicare enrollees for months beginning with April 1987.

* * * * *

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

* * * * *

EVIDENCE, PROCEDURE, AND CERTIFICATION FOR PAYMENT

SEC. 205. (a) * * *

* * * * *

(c)(1) For the purposes of this subsection—

(A) * * *

* * * * *

(D) The term "period" when used with respect to self-employment income means a taxable year and when used with respect to wages means—

(i) a quarter if wages were reported or should have been reported on a quarterly basis on tax returns filed with the Secretary of the Treasury or his delegate under section 6011 of the Internal Revenue Code of 1954 or regulations thereunder (or on reports filed by a State under section 218(e) *as in effect prior to December 31, 1986*) or regulations thereunder),

(5) After the expiration of the time limitation following any year in which wages were paid or alleged to have been paid to, or self-employment income was derived or alleged to have been derived by, an individual, the Secretary may change or delete any entry with respect to wages or self-employment income in his records of such year for such individual or include in his records of such year for such individual any omitted item of wages or self-employment income but only—

(A) * * *

* * * * *

(F) to conform his records to —

(i) * * *

* * * * *

(iii) assessments of amounts due under an agreement pursuant to section 218 *as in effect prior to December 31, 1986*, if such assessments are made within the period specified in subsection (q) of such section *as so in effect*, or allowances of credits or refunds of overpayments by a State under an agreement pursuant to such section;

* * * * *

COMPUTATION OF PRIMARY INSURANCE AMOUNT

SEC. 215. For the purposes of this title—

(a) * * *

* * * * *

Cost-of-Living Increases in Benefits

(i)(1) For purposes of this subsection—

(A) * * *

(B) the term "cost-of-living computation quarter" means a base quarter, as defined in subparagraph (A)(i), with respect to which the applicable increase percentage is [3 percent or more;] *greater than zero*; except that there shall be no cost-of-living computation quarter in any calendar year if in the year prior to such year a law has been enacted providing a general benefit increase under this title or if in such prior year such a general benefit increase becomes effective;

* * * * *

(2)(A) * * *

* * * * *

[(c)(i) Whenever the level of the Consumer Price Index as published for any month exceeds by 2.5 percent or more the level of such index for the most recent base quarter (as defined in paragraph (1)(A)(ii)) or, if later, the most recent cost-of-living computation quarter, the Secretary shall (within 5 days after such publication) report the amount of such excess to the House Committee on Ways and Means and the Senate Committee on Finance.]

[(ii)] (i) Whenever the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall notify the House Committee on Ways and Means and the Senate Committee on Finance of such determination within 30 days after the close of such quarter, indicating the amount of the benefit increase to be provided, his estimate of the extent to which the cost of such increase would be met by an increase in the contribution and benefit base under section 230 and the estimated amount of the increase in such base, the actuarial estimates of the effect of such increase, and the actuarial assumptions and methodology used in preparing such estimates.

[(iii)] (ii) The Secretary shall determine and promulgate the OASDI fund ratio for the current calendar year and the SSA wage index for the preceding calendar year before November 1 of the current calendar year, based upon the most recent data then available, and shall include a statement of such fund ratio and wage index (and of the effect such ratio and the level of such index may have upon benefit increases under this subsection) in any notification made under clause [(ii)] (i) and any determination published under subparagraph (D).

* * * * *

(4) This subsection as in effect in December 1978, and as amended by sections 111(a)(6), 111(b)(2), and 112 of the Social Security Amendments of 1983 and by section of the Omnibus Budget Reconciliation Act of 1986, shall continue to apply to subsections (a) and (d), as then in effect, for purposes of computing the primary insurance amount of an individual to whom subsection (a), as in effect after December 1978, does not apply (including an individual to whom subsection (a) does not apply in any year by reason of paragraph (4)(B) of that subsection (but the application of this subsection in such cases shall be modified by the application of subdivision (I) in the last sentence of paragraph (4) of that subsection)), except that for this purpose, in applying paragraphs (2)(A)(ii), (2)(D)(iv), and (2)(D)(v) of this subsection as in effect in December 1978, the phrase "increased to the next higher multiple of \$0.10" shall be deemed to read "decreased to the next lower multiple of \$0.10". For purposes of computing primary insurance amounts and maximum family benefits (other than primary insurance amounts and maximum family benefits for individuals to whom such paragraph (4)(B) applies), the Secretary shall revise the table of benefits contained in subsection (a), as in effect in December 1978, in accordance with the requirements of paragraph (2)(D) of this subsection as then in effect, except that the requirement in such para-

graph (2)(D) that the Secretary publish such revision of the table of benefits in the Federal Register shall not apply.

(5)(A) If—

(i) with respect to any calendar year the “applicable increase percentage” was determined under clause (ii) of paragraph (1)(C) rather than under clause (i) of such paragraph, and the increase becoming effective under paragraph (2) in such year was accordingly determined on the basis of the wage increase percentage rather than the CPI increase percentage (or there was no such increase becoming effective under paragraph (2) in that year because [the wage increase percentage was less than 3 percent] *there was no wage increase percentage greater than zero*), and

* * * * *

[Section 215 of the Social Security Act, as in effect December 1978]

Computation of Primary Insurance Amount

SEC. 215. For the purposes of this title—

(a) * * *

Cost-of-Living Increases in Benefits

(i)(1) For purposes of this subsection—

(A) * * *

(B) the term “cost-of-living computation quarter” means a base quarter, as defined in subparagraph (A)(i), in which the Consumer Price Index prepared by the Department of Labor exceeds[, by not less than 3 per centum,] such Index in the later of (i) the last prior cost-of-living computation quarter which was established under this subparagraph, or (ii) the most recent calendar quarter in which occurred the effective month of a general benefit increase under this title; except that there shall be no cost-of-living computation quarter in any calendar year if in the year prior to such year a law has been enacted providing a general benefit increase under this title or if in such prior year such a general benefit increase becomes effective;

* * * * *

(C) [(i) Whenever the level of the Consumer Price Index as published for any month exceeds by 2.5 percent or more the level of such index for the most recent base quarter (as defined in paragraph (1) (A) (ii)) or, if later, the most recent cost-of-living computation quarter, the Secretary shall (within 5 days after such publication) report the amount of such excess to the House Committee on Ways and Means and the Senate Committee on Finance.]

[(ii) (i) Whenever the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall notify the House Committee on Ways and Means and the Senate Committee on Finance of such determination within 30 days after the close of such quarter, indicating the amount of the benefit increase to be provided, his estimate of the extent to which the cost of such increase would be met by an increase [in the con-

tribution and benefit base under section 230 and the estimated amount of the increase in such base], the actuarial estimates of the effect of such increase, and the actuarial assumptions and methodology used in preparing such estimate.

[(iii)] (ii) The Secretary shall determine and promulgate the OASDI fund ratio for the current calendar year and the SSA wage index for the preceding calendar year before November 1, of the current calendar year, based upon the most recent data then available, and shall include a statement of such fund ratio and wage index (and of the effect such ratio and the level of such index may have upon benefit increases under this subsection) in any notification made under clause (ii) and any determination published under subparagraph (D).

* * * * *

VOLUNTARY AGREEMENTS FOR COVERAGE OF STATE AND LOCAL EMPLOYEES

Purpose of Agreement

SEC. 218. (a) * * *

* * * * *

POSITIONS COVERED BY RETIREMENT SYSTEMS

(d)(1) * * *

* * * * *

(6)(A) If a retirement system covers positions of employees of the State and positions of employees of one or more political subdivisions of the State, or covers positions of employees of two or more political subdivisions of the State, then, for purposes of the preceding paragraphs of this subsection, there shall, if the State so desires, be deemed to be a separate retirement system with respect to any one or more of the political subdivisions concerned and, where the retirement system covers positions of employees of the State, a separate retirement system with respect to the State or with respect to the State and any one or more of the political subdivisions concerned. Where a retirement system covering positions of employees of a State and positions of employees of one or more political subdivisions of a State, or covering positions of employees of two or more political subdivisions of the State, is not divided into separate retirement systems pursuant to the preceding sentence or pursuant to subparagraph (C), then the State may, for purposes of subsection [(f)] (e) only, deem the system to be a separate retirement system with respect to any one or more of the political subdivisions concerned and, where the retirement system covers positions of employees of the State, a separate retirement system with respect to the State or with respect to the State and any one or more of the political subdivisions concerned.

* * * * *

(F) In the case of any retirement system divided pursuant to subparagraph (C), the position of any member of the division or part composed of positions of members who do not desire coverage may

be transferred to the separate retirement system composed of positions of members who desire such coverage if it is so provided in a modification of such agreement which is mailed, or delivered by other means, to the Secretary prior to 1970 or, if after, the expiration of two years after the date on which such agreement, or the rate retirement system, as the case may be, is agreed to, but only if, prior to such modification or such later modification, as the case may be, the individual occupying such position files with the State a written request for such transfer. Notwithstanding subsection [(f)(1),] (e)(1), any such modification or later modification, providing for the transfer of additional positions within a retirement system previously divided pursuant to subparagraph (C) to the separate retirement system composed of positions of member who desire coverage, shall be effective with respect to services performed after the same effective date as that which was specified in the case of such previous division.

* * * * *

(8)(A) * * *

* * * * *

(D) Except in the case of agreements with the States named in subsection [(p)] (l) and agreements with interstate instrumentalities, nothing in this paragraph shall authorize the application of an agreement to service in any policeman's or fireman's position.

[Payments and Reports by States

[(e)(1) Each agreement under this section shall provide—

[(A) that the State will pay to the Secretary of the Treasury—

[(i) on the last day of each calendar month, amounts equivalent to the sum of the taxes which would be imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954 with respect to the period which includes the first fifteen days of such calendar month if the services for which wages were paid in such period to employees covered by the agreement constituted employment as defined in section 3121 of such Code, and

[(ii) on the fifteenth day of the calendar month following such calendar month, amounts equivalent to the sum of the taxes which would be imposed by sections 3101 and 3111 of such Code with respect to the period beginning with the sixteenth day of such calendar month and ending with the last day of such calendar month if the services for which wages were paid in such period to employees covered by the agreement constituted employment as defined in section 3121 of such Code; and

[(B) that the State will comply with such regulations relating to payments and reports as the Secretary of Health, Education, and Welfare may prescribe to carry out the purposes of this section.

[(2) Where—

[(A) an individual in any calendar year performs services to which an agreement under this section is applicable (i) as the

employee of two or more political subdivisions of a State or (ii) as the employee of State and one or more political subdivisions of such State; and

[(B) such State provides all of the funds for the payment of those amounts referred to in paragraph (1)(A) which are equivalent to the taxes imposed by section 3111 of the Internal Revenue Code of 1954 with respect to wages paid to such individual for such services; and

[(C) the political subdivision or subdivisions involved do not reimburse such State for the payment of such amounts or, in the case of services described in subparagraph (A)(ii), for the payment of so much of such amounts as is attributable to employment by such subdivision or subdivisions;

then, notwithstanding paragraph (1), the agreement under this section with such State may provide (either in the original agreement or by a modification thereof) that the amounts referred to in paragraph (1)(A) may be computed as though the wages paid to such individual for the services referred to in clause (A) of this paragraph were paid by one political subdivision for services performed in its employ; but the provisions of this paragraph shall be applicable only where such State complies with such regulations as the Secretary may prescribe to carry out the purposes of this paragraph. The preceding sentence shall be applicable with respect to wages paid after an effective date specified in such agreement or modification, but in no event with respect to wages paid before (i) January 1, 1957, in the case of an agreement or modification which is mailed or delivered by other means to the Secretary before January 1, 1962, or (ii) the first day of the year in which the agreement or modification is mailed or delivered by other means to the Secretary, in the case of an agreement or modification which is so mailed or delivered on or after January 1, 1962.]

Effective Date of Agreement

[(f)](e)(1) [Except as provided in subsection (e)(2), any] Any agreement or modification of an agreement under this section shall be effective with respect to services performed after an effective date specified in such agreement or modification; except that such date may not be earlier than the last day of the sixth calendar year preceding the year in which such agreement or modification, as the case may be, is mailed or delivered by other means to the Secretary.

* * * * *

Duration of Agreement

[(g)](f) No agreement under this section may be terminated, either in its entirety or with respect to any coverage group, on or after the date of the enactment of the Social Security Amendments of 1983.

[Deposits in Trust Fund; Adjustments

[(h)(1) All amounts received by the Secretary of the Treasury under an agreement made pursuant to this section shall be deposit-

ed in the Trust Funds and the Federal Hospital Insurance Trust Fund in the ratio in which amounts are appropriated to such Funds pursuant to subsection (a)(3) of section 201, subsection (b)(1) of such section, and subsection (a)(1) of section 1817, respectively.

[(2) If more or less than the correct amount due under an agreement made pursuant to this section is paid with respect to any payment of remuneration, proper adjustments with respect to the amounts due under such agreement shall be made, without interest, in such manner and at such times as may be prescribed by regulations of the Secretary.

[(3) If an overpayment cannot be adjusted under paragraph (2), the amount thereof and the time or times it is to be paid shall be certified by the Secretary to the Managing Trustee, and the Managing Trustee, through the Fiscal Service of the Treasury Department and prior to any action thereon by the General Accounting Office, shall make payment in accordance with such certification. The Managing Trustee shall not be held personally liable for any payment or payments made in accordance with a certification by the Secretary.

【Regulations

[(i) Regulations of the Secretary to carry out the purposes of this section shall be designed to make the requirements imposed on States pursuant to this section the same, so far as practicable, as those imposed on employers pursuant to this title and chapter 21 and subtitle F of the Internal Revenue Code of 1954.

【Failure To Make Payments

[(j) In case any State does not make, at the time or times due, the payments provided for under an agreement pursuant to this section, there shall be added, as part of the amounts due, interest at the rate of 6 per centum per annum from the date due until paid, and the Secretary may, in his discretion, deduct such amounts plus interest from any amounts certified by him to the Secretary of the Treasury for payment to such State under any other provision of this Act. Amounts so deducted shall be deemed to have been paid to the State under such other provision of this Act. Amounts equal to the amounts deducted under this subsection are hereby appropriated to the Trust Funds in the ratio in which amounts are deposited in such Funds pursuant to subsection (h)(1).】

Instrumentalities of Two or More States

[(k)](g)(1) The Secretary may, at the request of any instrumentality of two or more states, enter into an agreement with such instrumentality for the purpose of extending the insurance system established by this title to services performed by individual as employees of such instrumentality. Such agreement, to the extent practicable, shall be governed by the provisions of this section applicable in the case of an agreement with a State.

Delegation of Functions

[(1)] *(h)* The Secretary is authorized, pursuant to agreement with the head of any Federal agency, to delegate any of his functions under this section to any officer or employee of such agency and otherwise to utilize the services and facilities of such agency in carrying out such functions, and payment therefor shall be in advance or by way of reimbursement, as may be provided in such agreement.

Wisconsin Retirement Fund

[(m)] *(i)(1)* Notwithstanding paragraph (1) of subsection (d), the agreement with the State of Wisconsin may, subject to the provision of this subsection, be modified so as to apply to service performed by employees in positions covered by the Wisconsin retirement fund or any successor system.

* * * * *

Certain Positions No Longer Covered by Retirement Systems

[(n)] *(j)* Notwithstanding subsection (d), an agreement with any State entered into under this section prior to the date of the enactment of this subsection may, prior to January 1, 1958, be modified pursuant to subsection (c)(4) so as to apply to services performed by employees, as members of any coverage group to which such agreement already applies (and to which such agreement applied on such date of enactment, in positions (1) to which such agreement does not already apply, (2) which were covered by a retirement system on the date such agreement was made applicable to such coverage group, and (3) which, by reason of action by such State or political subdivision thereof, as may be appropriate, taken prior to the date of the enactment of this subsection, are no longer covered by a retirement system on the date such agreement is made applicable to such services.

Certain Employees of the State of Utah

[(o)] *(k)* Notwithstanding the provisions of subsection (d), the agreement with the state of Utah entered into pursuant to this section may be modified pursuant to subsection (c)(4) so as to apply to services performed for any of the following, the employees performing services for each of which shall constitute a separate coverage group: Weber Junior College, Carbon Junior College, Dixie Junior College, Central Utah Vocational School, Salt Lake Area Vocational School, Center for the Adult Blind, Union High School (Roosevelt, Utah), Utah High School Activities Association, State Industrial School, State Training School, State Board of Education, and Utah School Employees Retirement Board. Any modification agreed to prior to January 1, 1955, may be made effective with respect to services performed by employees as members of any such coverage groups after an effective date specified therein, except that in no case may any such date be earlier than December 31, 1950. Coverage provided for in this subsection shall not be affected by a subsequent change in the name of a group.

Policemen and Firemen in Certain States

[(p)](1) Any agreement with the State of Alabama, California, Florida, Georgia, Hawaii, Idaho, Kansas, Maine, Maryland, Mississippi, Montana, New York, North Carolina, North Dakota, Oregon, Puerto Rico, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, or Washington entered into pursuant to this section prior to the date of enactment of this subsection may notwithstanding the provisions of subsection (d)(5)(A) and the references thereto in subsections (d)(1) and (d)(3), be modified pursuant to subsection (c)(4) to apply to service performed by employees of such State or any political subdivision thereof in any policeman's or fireman's position covered by a retirement system in effect on or after the date of the enactment of this subsection, but only upon compliance with the requirements of subsection (d)(3). For the purposes of the preceding sentence, a retirement system which covers positions of policemen or firemen, or both, and other positions shall, if the State concerned so desires, be deemed to be a separate retirement system with respect to the positions of such policemen or firemen, or both, as the case may be.

(2) A State, not otherwise listed by name in paragraph (1), shall be deemed to be a State listed in such paragraph for the purpose of extending coverage under this title to service in firemen's positions covered by a retirement system, if the governor of the State, or an official of the State designated by him for the purpose, certifies to the Secretary that the overall benefit protection of the employees in such positions would be improved by reason of the extension of such coverage to such employees. Notwithstanding the provisions of the second sentence of such paragraph (1), such firemen's positions shall be deemed a separate retirement system and no other positions shall be included in such system.

[TIME LIMITATIONS ON ASSESSMENTS

[(q)(1) Where a State is liable for an amount due under an agreement pursuant to this section, such State shall remain so liable until the Secretary is satisfied that the amount due has been paid to the Secretary of the Treasury.

[(2) Notwithstanding paragraph (1), a State shall not be liable for an amount due under an agreement pursuant to this section, with respect to the wages paid to individuals, after the expiration of the latest of the following periods—

[(A) three years, three months, and fifteen days after the year in which such wages were paid, or

[(B) three years after the date on which such amount became due, or

[(C) three years, three months, and fifteen days after the year following the year in which this subsection is enacted, unless prior to the expiration of such period the Secretary makes an assessment of the amount due.

[(3) For purposes of this subsection and section 205(c), an assessment of an amount due is made when the Secretary mails or otherwise delivers to the State a notice stating the amount he has determined to be due under an agreement pursuant to this section and the basis for such determination.

[(4) An assessment of an amount due made by the Secretary after the expiration of the period specified in paragraph (2) shall nevertheless be deemed to have been made within such period if—

[(A) before the expiration of such period (or, if it has previously been extended under this paragraph, of such period as so extended), the State and the Secretary agree in writing to an extension of such period (or extended period) and, subject to such conditions as may be agreed upon, the Secretary makes the assessment prior to the expiration of such extension; or

[(B) within the 365 days immediately preceding the expiration of such period (or extended period) the State pays to the Secretary of the Treasury less than the correct amount due under an agreement pursuant to this section with respect to wages paid to individuals in a calendar year as members of a coverage group, and the Secretary of Health and Human Services makes the assessment, adjusted to take into account the amount paid by the State, no later than the 365th day after the day the State made payment to the Secretary of the Treasury; but the Secretary of Health and Human Services shall make such assessment only with respect to the wages paid to such individuals in such calendar year as members of such coverage group; or

[(C) pursuant to subparagraph (A) or (B) of section 205(c)(5) he includes in his records an entry with respect to wages for an individual, but only if such assessment is limited to the amount due with respect to such wages and is made within the period such entry could be made in such records under such subparagraph.

[(5) If the Secretary allows a claim for a credit or refund of an overpayment by a State under an agreement pursuant to this section, with respect to wages paid or alleged to have been paid to an individual in a calendar year for services as a member of a coverage group, and if as a result of the facts on which such allowance is based there is an amount due from the State, with respect to wages paid to such individual in such calendar year for services performed as a member of a coverage group, for which amount the State is not liable by reason of paragraph (2), then notwithstanding paragraph (2) the State shall be liable for such amount due if the Secretary makes an assessment of such amount due at the time of or prior to notification to the State of the allowance of such claim. For purposes of this paragraph and paragraph (6), interest as provided for in subsection (j) shall not be included in determining the amount due.

[(6) The Secretary shall accept wage reports filed by a State under an agreement pursuant to this section or regulations of the Secretary thereunder, after the expiration of the period specified in paragraph (2) or such period as extended pursuant to paragraph (4), with respect to wages which are paid to individuals performing services as employees in a coverage group included in the agreement and for payment in connection with which the State is not liable by reason of paragraph (2), only if the State—

[(A) pays to the Secretary of the Treasury the amount due under such agreement with respect to such wages, and

[(B) agrees in writing with the Secretary of Health and Human Services to an extension of the period specified in paragraph (2) with respect to wages paid to all individuals performing services as employees in such coverage group in the period or periods designated by the State in such wage reports as the period or period in which such wages were paid. If the State so agrees, the period specified in paragraph (2), or such period as extended pursuant to paragraph (4), shall be extended until such time as the Secretary notifies the State that such wage reports have been accepted.

[(7) Notwithstanding the preceding provisions of this subsection, where there is an amount due by a State under an agreement pursuant to this section and there has been a fraudulent attempt on the part of an officer or employee of the State or any political subdivision thereof to defeat or evade payment of such amount due, the State shall be liable for such amount due without regard to the provisions of paragraph (2), and the Secretary may make an assessment of such amount due at any time.

[Time Limitation on Credits and Refunds

[(r)(1) No credit refund of an overpayment by a State under an agreement pursuant to this section with respect to wages paid or alleged to have been paid to an individual as a member of a coverage group in a calendar year shall be allowed after the expiration of the latest of the following periods—

[(A) three years, three months, and fifteen days after the year in which such wages were paid or alleged to have been paid, or

[(B) three years after the date the payment which included such overpayment became due under such agreement with respect to the wages paid or alleged to have been paid to such individual as a member of such coverage group in such calendar year, or

[(C) two years after such overpayment was made to the Secretary of the Treasury, or

[(D) three years, three months, and fifteen days after the year following the year in which this subsection is enacted, unless prior to the expiration of such period a claim for such credit or refund is filed with the Secretary of Health and Human Services by the State.

[(2) A claim for a credit or refund filed by a State after the expiration of the period specified by paragraph (1) shall nevertheless be deemed to have been filed within such period if—

[(A) before the expiration of such period (or, if it has previously been extended under this subparagraph, of such period as so extended) the State and the Secretary agree in writing to an extension of such period (or extended period) and the claim is filed with the Secretary by the State prior to the expiration of such extension; but any claim for a credit or refund valid because of this subparagraph shall be allowed only to the extent authorized by the conditions provided for in the agreement for such extension, or

[(B) the Secretary deletes from his records an entry with respect to wages of an individual pursuant to the provisions of subparagraph (A), (B), or (E) of section 205(c)(5), but only with respect to the entry so deleted.

[Review by Secretary

[(s) Where the Secretary has made an assessment of an amount due by a State under an agreement pursuant to this section, disallowed a State's claim for a credit or refund of an overpayment under such agreement, or allowed a State a credit or refund of an overpayment under such agreement, he shall review such assessment, disallowance, or allowance if a written request for such review is filed with him by the State within 90 days (or within such further time as he may allow) after notification to the State of such assessment, disallowance, or allowance. On the basis of the evidence obtained by or submitted to the Secretary, he shall render a decision affirming, modifying, or reversing such assessment, disallowance, or allowance. In notifying the State of his decision, the Secretary shall state the basis therefor.

[Review by Court

[(t)(1) Notwithstanding any other provision of this title any State, irrespective of the amount in controversy, may file, within two years after the mailing to such State of the notice of any decision by the Secretary pursuant to subsection (s) affecting such State, or within such further time as the Secretary may allow, a civil action for a redetermination of the correctness of the assessment of the amount due, the disallowance of the claim for a refund or credit, or the allowance of the refund or credit, as the case may be, with respect to which the Secretary has rendered such decision. Such action shall be brought in the district court of the United States for the judicial district in which is located the capital of such State, or, if such action is brought by an instrumentality of two or more States, the principal office of such instrumentality. The judgment of the court shall be final, except that it shall be subject to review in the same manner as judgments of such court in other civil actions. Any action filed under this subsection shall survive notwithstanding any change in the person occupying the office of Secretary or any vacancy in such office.

[(2) Notwithstanding the provisions of section 2411 of title 28, United States Code, no interest shall accrue to a State after final judgment with respect to a credit or refund of an overpayment made under an agreement pursuant to this section.

[(3) The first sentence of section 2414 of title 28, United States Code, shall not apply to final judgments rendered by district courts of the United States in civil actions filed under this subsection. In such cases, the payment of amounts due to States pursuant to such final judgments shall be adjusted in accordance with the provisions of this section and with regulations promulgated by the Secretary.]

Positions Compensated Solely on a Fee Basis

[(u)](m)(1) Notwithstanding any other provision in this section, an agreement entered into under this section may be made applicable to service performed after 1967 in any class or classes of positions compensated solely on a fee basis to which such agreement did not apply prior to 1968 only if the State specifically requests that its agreement be made applicable to such service in such class or classes of positions.

* * * * *

REDUCTION OF BENEFITS BASED ON DISABILITY

SEC. 224. (a) If for any month prior to the month in which an individual attains the age of 65—

(1) * * *

(2) such individual is entitled for such month to—

(A) periodic benefits on account of his or her total or partial disability (whether or not permanent) under a workmen's compensation law or plan of the United States or a State, or

(B) periodic benefits on account of his or her total or partial disability (whether or not permanent) under any other law or plan of the United States, a State, a political subdivision (as that term is used in section 218(b)(2)), or an instrumentality of two or more States (as that term is used in section [218(k)] 218(g)), other than (i) benefits payable under title 38, United States Code, (ii) benefits payable under a program of assistance which is based on need, (iii) benefits based on service all or substantially all of which was included under an agreement entered into by a State and the Secretary under section 218, and (iv) benefits under a law or plan of the United States based on service all or substantially all of which is employment as defined in section 210,

* * * * *

TITLE IV—GRANTS TO STATES FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN AND FOR CHILD-WELFARE SERVICES

* * * * *

PART A—AID TO FAMILIES WITH DEPENDENT CHILDREN

* * * * *

STATE PLANS FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN

SEC. 402. (a) A State plan for aid and services to needy families with children must—

(1) * * *

* * * * *

(38) provide that in making the determination under paragraph (7) with respect to a dependent child and applying paragraph (8), the State agency shall (except as otherwise provided in this part) include—

(A) any parent of such child, and

(B) any brother or sister of such child, if such brother or sister meets the conditions described in clauses (1) and (2) of section 406(a), if such parent, brother, or sister is living in the same home as the dependent child, and any income of or available for such parent, brother, or sister shall be included in making such determination and applying such paragraph with respect to the family (notwithstanding section 205(j), in the case of benefits provided under title II);

[and]

(39) provide that in making the determination under paragraph (7) with respect to a dependent child whose parent or legal guardian is under the age selected by the State pursuant to section 406(a)(2), the State agency shall (except as otherwise provided in this part) include any income of such minor's own parents or legal guardians who are living in the same home as such minor and dependent child, to the same extent that income of a stepparent is included under paragraph (31)**[.]**; and

(40) provide that payments of aid will be made under the plan with respect to dependent children of unemployed parents, in accordance with section 407.

* * * * *

DEPENDENT CHILDREN OF UNEMPLOYED PARENTS

SEC. 407. (a) * * *

[(b) The provisions of subsection (a) shall be applicable to a State if the State's plan approved under section 402—

[(1) requires] (b) In providing for the payment of aid under the State's plan approved under section 402 in the case of families which include dependent children within the meaning of subsection (a) of this section, as required by section 402(a)(40), the State's plan—

(1) shall require the payment of aid to families with dependent children with respect to a dependent child as defined in subsection (a) when—

(A) * * *

* * * * *

(C)(i) such parent has 6 or more quarters of work (as defined in subsection (d)(1)), *including 2 or more quarters of work as defined in subsection (d)(1)(A)*, in any 13-calendar-quarter period ending within one year prior to the application for such aid or (ii) such parent received unemployment compensation under an unemployment compensation law of a State or of the United States, or such parent was qualified (within the meaning of subsection (d)(3)) for unemployment compensation under the unemployment com-

pensation law of the State, within one year prior to the application for such aid; and

(2) **【provides—】 shall provide—**

(A) for such assurances as will satisfy the Secretary that unemployed parents of dependent children as defined in subsection (a) will be certified to the Secretary of Labor as provided in section 402(a)(19) within 30 days after receipt of aid with respect to such children;

* * * * *

(d) For purposes of this section—

(1) the term “quarter of work” with respect to any individual means a calendar quarter (A) in which such individual received earned income of not less than \$50 (or which is a “quarter of coverage” as defined in section 213(a)(2)), or in which such individual participated in a community work experience program under section 409, or the work incentive program established under part C, or (B) *if the State plan so provides (but subject to the last sentence of this subsection), in which such individual (i) was in regular full-time attendance as a student at an elementary or secondary school, (ii) was in regular full-time attendance in a course of vocational or technical training designed to fit him or her for gainful employment, or (iii) participated in an education or training program established under the Job Training Partnership Act;*

* * * * *

(4) the phrase “whichever of such child’s parents is the principal earner”, in the case of any child, means whichever parent, in a home in which both parents of such child are living, earned the greater amount of income in the 24-month period the last month of which immediately precedes the month in which an application is filed for aid under this part on the basis of the unemployment of a parent, for each consecutive month for which the family receives such aid on that basis.

No individual shall be credited during his or her lifetime (for purposes of subsection (b)(1)(C)(i)) with more than 4 “quarters of work” based on attendance in a course or courses of vocational or technical training as described in paragraph (1)(B)(ii) of this subsection.

* * * * *

TITLE XI—GENERAL PROVISIONS AND PEER REVIEW

* * * * *

PART A—GENERAL PROVISIONS

* * * * *

INCOME AND ELIGIBILITY VERIFICATION SYSTEM

SEC. 1137. (a) In order to meet the requirements of this section, a State must have in effect an income and eligibility verification system under which—

(1) * * *

* * * * *

(4) the State agencies administering the programs listed in subsection (b) adhere to standardized formats and procedures established by the Secretary of Health and Human Services (in consultation with the Secretary of Agriculture) under which—

(A) * * *

* * * * *

(C) the use of such information shall be targeted to those uses which are most likely to be productive in identifying and preventing ineligibility and incorrect payments, *and no State shall be required to use such information to verify the eligibility of all recipients,*

* * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a) * * *

* * * * *

(f)(1) * * *

(2) If paragraph (1) does not apply to the monthly premiums for 1986, 1987, or 1988, if an individual is entitled to monthly benefits under section 202 or 223 for November and for December in the preceding year, and if the monthly premium for that December and for the following January is deducted from those benefits under section 1840(a)(1), the monthly premium for that individual for that January and for each of the succeeding 11 months for which he is entitled to benefits under section 202 or 223 shall (except as otherwise provided in subsection (b)) be the greater of—

[(A) the monthly premium amount determined under subsection (a)(2) for that January reduced by the amount (if any) necessary to make the monthly benefits under section 202 or 223 for that December after the deduction of the monthly premium (disregarding subsection (b)) for that January at least equal to the monthly benefits under section 202 or 223 for the preceding November after the deduction of the premium (disregarding subsection (b)) for that individual for that December, or]

(A) the monthly premium amount determined under subsection (a)(2) for that January reduced by the amount (if any) by which the monthly benefit under section 202 or 223 for that November, after the deduction of the premium (disregarding subsection (b)) for that individual for that December and after

rounding under section 215(g), would exceed the monthly benefit under section 202 or 223 for that December, after the deduction of the monthly premium amount determined under subsection (a)(2) (disregarding subsection (b)) for that individual for that January and after rounding under section 215(g), or

* * * * *

INTERNAL REVENUE CODE

* * * * *

Subtitle A—Income Taxes

* * * * *

CHAPTER 2—TAX ON SELF-EMPLOYMENT INCOME

* * * * *

SEC. 1402. DEFINITIONS.

(a) NET EARNINGS FROM SELF-EMPLOYMENT.— * * *

(b) SELF-EMPLOYMENT INCOME.—The term “self-employment income” means the net earning from self-employment derived by an individual (other than a nonresident alien individual, except as provided by an agreement under section 233 of the Social Security Act) during any taxable year; except that such term shall not include—

(1) that part of the net earnings from self-employment which is in excess of (i) an amount equal to the contribution and benefit base (as determined under section 230 of the Social Security Act*) which is effective for the calendar year in which such taxable year begins, minus (ii) the amount of the wages paid to such individual during such taxable years; or

(2) the net earnings from self-employment, if such net earnings for the taxable year are less than \$400.

For purposes of clause (1), the term “wages” (A) includes such remuneration paid to an employee for services included [under an agreement entered into pursuant to the provisions of section 218 of the Social Security Act (relating to coverage of State employees), or] under an agreement entered into pursuant to the provisions of section 3121(1) (relating to coverage of citizens of the United States who are employees of foreign affiliates of American employers), as would be wages under section 3121(a) if such services constituted employment under section 3121(b), (B) includes compensation which is subject to the tax imposed by section 3201 or 3211, and (C) includes, but only with respect to the tax imposed by section 1401(b), remuneration paid for medicare qualified government employment (as defined in section 3121(u)(3)) which is subject to the taxes imposed by sections 3101(b) and 3111(b). An individual who is not a citizen of the United States but who is a resident of the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa shall not, for purposes of this chapter be considered to be a nonresident alien individual.

* * * * *

CHAPTER 21—FEDERAL INSURANCE CONTRIBUTIONS ACT

* * * * *

Subchapter C—General Provisions

Sec. 3121. Definitions.

Sec. 3122. Federal service.

Sec. 3123. Deductions as constructive payments.

Sec. 3124. Estimate of revenue reduction.

Sec. 3125. Returns in the case of governmental employees in States, Guam, American Samoa, and the District of Columbia.

【Sec. 3126. Short title.】

Sec. 3126. *Return and payment by governmental employer.*

Sec. 3127. *Short title.*

SEC. 3121. DEFINITIONS.

(a) **WAGES.**— * * *

(b) **EMPLOYMENT.**—For purposes of this chapter, the term “employment” means any service, of whatever nature, performed (A) by an employee for the person employing him, irrespective of the citizenship or residence of either, (i) within the United States, or (ii) on or in connection with an American vessel or American aircraft under a contract of service which is entered into within the United States or during the performance of which and while the employee is employed on the vessel or aircraft it touches at a port in the United States, if the employee is employed on and in connection with such vessel or aircraft when outside the United States, or (B) outside the United States by a citizen of the United States [a citizen or resident of the United States (effective for remuneration paid after December 31, 1983)] as an employee for an American employer (as defined in subsection (h)), or (C) if it is service, regardless of where or by whom performed, which is designated as employment or recognized as equivalent to employment under an agreement entered into under section 233 of the Social Security Act; except that such term shall not include—

(1) * * *

* * * * *

(7) service performed in the employ of a State, or any political subdivision thereof, or any instrumentality of any one or more of the foregoing which is wholly owned thereby, except that this paragraph shall not apply in the case of—

(A) * * *

* * * * *

(C) service performed in the employ of the District of Columbia or any instrumentality which is wholly owned thereby, if such service is not covered by a retirement system established by a law of the United States; except that the provisions of this subparagraph shall not be applicable to service performed—

(i) in a hospital or penal institution by a patient or inmate thereof;

(ii) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Gov-

ernment), other than as a medical or dental intern or as a medical or dental resident in training;

(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency; or

(iv) by a member of a board, committee, or council of the District of Columbia, paid on a per diem, meeting, or other fee basis, [or]

(D) service performed in the employ of the Government of Guam (or any instrumentality which is wholly owned by such Government) by an employee properly classified as a temporary or intermittent employee, if such service is not covered by a retirement system established by a law of Guam; except that (i) the provisions of this subparagraph shall not be applicable to services performed by an elected official or a member of the legislature or in a hospital or penal institution by a patient or inmate thereof, and (ii) for purposes of this subparagraph, clauses (i) and (ii) of subparagraph (B) shall apply [;], or

(E) service included under an agreement entered into pursuant to section 218 of the Social Security Act;

* * * * *

(d) **EMPLOYEE.**—For purposes of this chapter, the term “employee” means—

(1) * * *

* * * * *

(3) *any individual who performs services that are included under an agreement entered into pursuant to section 218 of the Social Security Act; or*

[(3)] (4) any individual (other than an individual who is an employee under paragraph (1) or (2)) who performs services for remuneration for any person—

(A) as an agent-driver or commission-driver engaged in distributing meat products, vegetable products, bakery products, beverages (other than milk), or laundry or dry-cleaning services, for his principal;

(B) as a full-time life insurance salesman;

(C) as a home worker performing work, according to specifications furnished by the person for whom the services are performed, on materials or goods furnished by such person which are required to be returned to such person or a person designated by him; or

(D) as a traveling or city salesman, other than as an agent-driver or commission-driver, engaged upon a full-time basis in the solicitation on behalf of, and the transmission to, his principal (except for side-line sales activities on behalf of some other person) of orders from wholesalers, retailers, contractors, or operators of hotels, restaurants, or other similar establishments for merchandise for resale or supplies for use in their business operations;

* * * * *

SEC. 3126. RETURN AND PAYMENT BY GOVERNMENTAL EMPLOYER.

If the employer is a State or political subdivision thereof, or an agency or instrumentality of any one or more of the foregoing, the return of the amount deducted and withheld upon any wages under section 3101 and the amount of the tax imposed by section 3111 may be made by any officer or employee of such State or political subdivision or such agency or instrumentality, as the case may be, having control of the payment of such wages, or appropriately designated for that purpose.

SEC. [3126.] 3127. SHORT TITLE.

This chapter may be cited as the "Federal Insurance Contributions Act."

CHAPTER 23—FEDERAL UNEMPLOYMENT TAX ACT

* * * * *

SEC. 3301. RATE OF TAX.

There is hereby imposed on every employer (as defined in section 3306(a)) for each calendar year an excise tax, with respect to having individuals in his employ, equal to—

- (1) 6.2 percent, in the case of a calendar year beginning before the first calendar year after [1976,] 1989, as of January 1 of which there is not a balance of repayable advances made to the extended unemployed compensation account (established by section 905(a) of the Social Security Act); or

* * * * *

SEC. 3306. DEFINITIONS.**(a) EMPLOYER.— * * ***

* * * * *

(i) **EMPLOYER.**—For purposes of this chapter, the item "employee" has the meaning assigned to such term by section 3121(d), except that [subparagraphs (B) and (C) of paragraph (3)] *paragraph (3) and subparagraphs (B) and (C) of paragraph (4)* shall not apply.

* * * * *

SEC. 3311. SHORT TITLE.

This chapter may be cited as the "Federal Unemployment Tax Act."

* * * * *

Subtitle D—Miscellaneous Excise Taxes

* * * * *

CHAPTER 33—FACILITIES AND SERVICES

* * * * *

SEC. 4251. IMPOSITION OF TAX.**(a) TAX IMPOSED.— * * *****(b) DEFINITIONS.—For purposes of subsection (a)—**

- (1) * * *

(2) **APPLICABLE PERCENTAGE.**—The term “applicable percentage” means—

[With respect to amounts paid pursuant to bills first rendered:	<i>The applicable percentage is:</i>
[During 1983, 1984, 1986 or 1987.....	3
[During 1988 or thereafter	[0.]

With respect to amounts paid pursuant to bills first rendered:

<i>During 1987, 1988, or 1989</i>	<i>3</i>
<i>During 1990 or thereafter.....</i>	<i>0.</i>

* * * * *



99TH CONGRESS
2d Session

SENATE

REPORT
99-348

SIXTH OMNIBUS BUDGET RECONCILIATION
ACT, 1986

R E P O R T

OF THE

COMMITTEE ON THE BUDGET
UNITED STATES SENATE

TO ACCOMPANY

S. 2706

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO SECTION 2 OF THE CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 1987 (S. CON. RES. 120, NINETY-NINTH CONGRESS)

together with
ADDITIONAL AND MINORITY VIEWS



JULY 31 (legislative day, JULY 28), 1986.—Ordered to be printed

COMMITTEE ON THE BUDGET

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NANCY LANDON KASSEBAUM, Kansas
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SIXTH OMNIBUS BUDGET RECONCILIATION ACT, 1986

JULY 31 (legislative day, JULY 28), 1986.—Ordered to be printed

Mr. DOMENICI, from the Committee on the Budget,
submitted the following

REPORT

[To accompany S. 2706]

The Committee on the Budget, to which were submitted recommendations pursuant to section 2 of the Concurrent Resolution on the Budget for Fiscal Year 1987 (S. Con. Res. 120, Ninety-ninth Congress), having considered the same, reports favorably thereon and recommends that the bill embodying those recommendations do pass.

Table 3—Continued

[In millions of dollars]

		FY 1987	FY 1988	FY 1989	Total FY 1987-89
TITLE VI					
Finance Committee: Spending Provisions ³					
Medicare.....	BA	0	0	0	0
	O	-2,369	-617	-950	-3,936
Medicaid	BA	0	0	0	0
	O	135	257	351	743
Total spending reduction	BA	0	0	0	0
	O	-2,234	-360	-599	-3,193
Total spending instruction ...	BA	0	0	0	0
	O	-850	-1,495	-1,790	-4,135
TITLE VI-A					
Finance Committee: Revenue Provisions					
Extend medicare coverage		829	2,151	2,169	5,149
Cigarette tax.....		1,593	1,684	1,693	4,970
Total revenue increases		2,422	3,835	3,862	10,119
Total revenue instruction.....		3,500	2,600	2,400	8,500
Total Finance.....		-4,656	-4,195	-4,461	-13,312
Total Finance instruction.....		-4,350	-4,095	-4,190	-12,635
TITLE VII					
Governmental Affairs					
Federal employee retirement ⁴	BA	664	64	66	794
	O	-205	20	35	-150
Postal subsidy reforms.....	BA	0	0	-210	-210
	O	0	0	-210	-210
Total spending reduction	BA	664	64	-144	584
	O	-205	20	-175	-360
Total spending instruction ...	BA	-100	-100	-100	-300
	O	-100	-100	-100	-300

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United States Senate

COMMITTEE ON FINANCE
WASHINGTON, DC 20510

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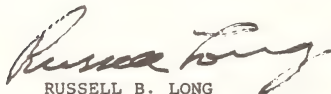
July 30, 1986

The Honorable Pete V. Domenici
Chairman
Committee on the Budget
United States Senate
Washington, D.C. 20510

Dear Pete:

We hereby submit the statutory language implementing the recommendations of the Committee on Finance to meet its reconciliation instructions under S. Con. Res. 120, the concurrent resolution on the budget for fiscal year 1987. Also enclosed are materials which explain these provisions.

These statutory provisions will reduce outlays for programs within the jurisdiction of the Committee on Finance by \$3.2 billion over fiscal years 1987-1989. In addition, the revenue provisions will increase Federal receipts by \$10.1 billion over the same period.



RUSSELL B. LONG
Ranking Minority Member

Sincerely,



BOB PACKWOOD
Chairman

(133)

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TITLE VI: OUTLAY PROVISIONS

A. Medicare Provisions

1. Payments for Inpatient Hospital Services

Current law.—The Social Security Amendments of 1983 (P.L. 98-21) authorized the Secretary of Health and Human Services (HHS) to determine the rate of increase in the prospective payment system (PPS) rates for FY 1986 and thereafter, taking into account the recommendations of the Prospective Payment Assessment Commission (ProPAC). The Deficit Reduction Act of 1984, P.L. 98-369 (DEFRA), limited the FY 1986 rate of increase to be determined by the Secretary to the rate of increase in the hospital marketbasket plus one-quarter of one percentage point. HHS issued final rules on September 3, 1985 freezing the PPS payment rates for FY 1986. However, these rules were not implemented because of the enactment of the Emergency Extension Act of 1985 (P.L. 99-107, as amended by P.L. 99-201), which provided that from October 1, 1985 through March 14, 1986, the FY 1986 PPS rates would be frozen at FY 1985 levels.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provided that the FY 1986 rate freeze continue until May 1, 1986, when the PPS rates would be increased one-half percent for the remainder of the year. In addition, for FY 1987 and FY 1988, it provided that the Secretary could determine any change in the PPS payment rates, taking into account the recommendations of the ProPAC, not to exceed the marketbasket index change. The rate of increase for PPS-exempt hospitals was $\frac{5}{4}$ of one percent, effective for hospital cost reporting periods beginning October 1, 1985, but before October 1, 1986. The Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177) reduced the FY 1986 Medicare payments to hospitals by one percent beginning March 1, 1986.

In proposed rules issued June 3, 1986, HHS provided for an increase of 0.5 percent in the FY 1987 PPS rates and in the target amounts per discharge for PPS-exempt hospitals. In its July 2, 1986 report to HCFA, ProPAC recommended a 2.2 percent rate of increase in FY 1987 PPS rates, a rate of increase for children's hospitals of 3.2 percent, and a rate of increase for other PPS-exempt hospitals and units of 3.5 percent.

PPS hospitals are paid, in part, on the basis of regional and national standardized amounts per discharge. Separate urban and rural standardized amounts are calculated for each of the nine census regions and for the nation. These standardized amounts represent the urban or rural operating cost per discharge averaged across all hospitals in the region (or nation). This results in amounts that represent the operating cost per discharge for the av-

erage hospital. Additional amounts are paid to PPS hospitals for "outliers"—atypical cases which have extraordinarily high costs or involve extraordinarily long hospital stays compared to most patients classified in the same DRG. The law requires that total outlier payments to all hospitals represent no less than 5 percent and no more than 6 percent of the total estimated Medicare prospective payments based on the DRG payment rates for the fiscal year.

Rural hospitals may apply for designation as rural referral centers. In order to qualify, hospitals must meet criteria based on bed size or national or regional criteria based on case mix, admission volume, or patient referrals. Hospitals meeting these criteria are paid prospective payments based on the applicable urban payment rates, rather than the rural rates, as adjusted by the hospital's area wage index.

The provision would provide an increase in the payment rates for PPS hospitals and in the target amounts for PPS-exempt hospitals in FY 1987 of 1.5 percent.

Although the Committee is recommending a 1.5 percent increase for both PPS and PPS-exempt hospitals, the Committee understands there are presently two distinct Medicare hospital payment systems in operation—hospitals paid under PPS and hospitals paid under the TEFRA per case cost limits. It is the Committee's view that the criteria utilized to develop an update factor for PPS-exempt hospitals should be specific to the operation of these facilities. Therefore, the Committee recommends that the Secretary consider the ProPAC recommendations regarding a separate update factor for PPS-exempt hospitals and urges the Secretary for FY 1988 and for subsequent fiscal years to utilize those criteria that are specific to the operation of PPS-exempt hospitals in developing an update factor for those facilities.

The current formula used to calculate the average standardized amounts for urban and for rural hospitals under PPS would be changed to be based on the number of patients discharged rather than the number of hospitals. This would result in amounts that represent the operating cost per discharge for the average patient as opposed to the average hospital. The effect of this provision would be to shift payments from urban hospitals to rural hospitals.

Medicare law would be amended so that the total amount of payments for outliers to sole community hospitals, with an average occupancy of 50 beds or less, and to small rural hospitals would be required to be not less than 5 percent nor more than 6 percent of the total payments based on DRG prospective payment rates projected or estimated to be made to such hospitals in a given year.

The Prospective Payment Assessment Commission (ProPAC) would be required to include in its annual report an assessment of whether the outlier thresholds established by the Secretary each year (both the generally applicable thresholds and the new thresholds for small rural hospitals) are being set at the appropriate levels to insure that between 5 and 6 percent of the PPS payments are made for outliers.

Hospitals designated as rural referral centers as of the date of enactment of this Act shall retain that designation for cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989.

Effective date.—October 1, 1986.

2. Payments for Hospital Capital-Related Costs

Current law.—The Social Security Amendments of 1983 (P.L. 98-21) established a prospective payment system (PPS) for making payments to hospitals for the operating costs of inpatient services provided to Medicare beneficiaries. Payments for operating costs are made on the basis of fixed rates per discharge. Hospital capital-related costs of inpatient services (including depreciation, leases and rentals, interest, and a return on equity for proprietary hospitals) are excluded from PPS and are reimbursed on a reasonable cost basis. This exclusion was to expire on October 1, 1986, but enactment of the Urgent Supplemental Appropriations Act (P.L. 99-349) extended the exclusion until October 1, 1987.

In addition, under prior law, if Congress did not enact legislation by October 1, 1986 to include capital-related costs under PPS, Medicare payment for capital costs would be prohibited unless a State has a capital expenditure review agreement with the Secretary (under section 1122 of the Social Security Act) and the State has recommended approval of the specific capital expenditure. P.L. 99-349 extended the deadline for congressional action to October 1, 1987.

Explanation of provision.—The provision would reduce reimbursements to PPS hospitals for capital costs of inpatient services, otherwise payable under current law, by 3 percent in FY 1987, 5 percent in FY 1988 and 6 percent in FY 1989.

A hospital which is a sole community hospital pursuant to section 1886(d)(5)(C)(ii) of the Social Security Act would be exempt from the reductions. Under current law, a hospital which is paid as a sole community provider voluntarily may relinquish such status, and be paid in the same manner as other prospective payment system (PPS) hospitals. This provision would continue to apply, but any hospital which relinquished its status as a sole community provider prior to the date of enactment of this capital provision could reapply and requalify for sole community provider status.

It is the intent of the Committee to consider the issue of payment for capital-related costs next year, and to develop a capital payment proposal which moves to a prospective payment system, but also continues cost-based reimbursement for capital-related financial obligations incurred, or enforceable agreements entered into, prior to January 1, 1986. Such a proposal would also include a requirement that a payment adjustment for new capital (those capital-related costs not "grandfathered" under cost-based reimbursement) would be included for hospitals which serve a disproportionate share of low-income patients (if such an adjustment for disproportionate share is included in law for operating costs).

Effective date.—Hospital cost reporting periods beginning on or after October 1, 1986.

3. Medicare as Secondary Payer; Coverage Requirements for Certain Other Payers

Current law.—The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) required employers to offer their employees aged 65 through 69 the same group health plan offered to their employees

under age 65. DEFRA extended the provision to beneficiaries covered under a working spouse's employer-based health plan when that spouse is under age 65. COBRA extended this provision to the working aged and spouses over age 69. When the beneficiary elects such coverage, Medicare becomes the secondary payer. The beneficiary retains the option to be covered only by Medicare.

Explanation of provision.—The provision would make Medicare the secondary payer for all beneficiaries (including the disabled and those who buy into Medicare) who receive employment-based health benefits as a current employee (or family member) of an employer with 20 or more employees, and would explicitly include an employer, anyone associated with the employer in a business relationship (such as an agent or contractor) who is covered by the employer's health plan, and former employees who have not reached age 65. The provision would not otherwise enlarge the obligations of employers under current law. The provision also states explicitly that these group health plan requirements (and similar ones for end stage renal disease (ESRD) and for workers' compensation and liability and related insurance) would be enforceable by private action or by the Federal Government (with double the damages payable), and would impose an excise tax equal to 25 percent of group health plan expenses if the requirements were not met. Federal Medicaid payments to a State would be reduced by 25 percent of group health plan expenses of a State (or State or local governmental entity) that did not comply. Enforcement through the Equal Employment Opportunity Commission (EEOC) would be eliminated.

Finally, the provision would provide uniform rules as to the benefits Medicare pays when other payers are primary but do not pay the full charge. In particular, payment under workers' compensation or liability and related insurance is not now counted toward the Medicare deductible, but would be under this provision.

It is the Committee's intent that the Department of Health and Human Services would consult with the Departments of Treasury and Labor in implementing this provision.

Effective date.—October 1, 1986.

4. Payments for Physicians' Services

Current law.—Payments are made to physicians on the basis of reasonable charges. The reasonable charge for a service is the lowest of the actual charge, the physician's customary charge for the service or the prevailing charge for the service in the community.

DEFRA froze physician fees for the 15 month period July 1, 1984 through September 30, 1985. The Emergency Extension Act (P.L. 99-107), as amended, and COBRA extended this freeze through April 30, 1986 for participating physicians and December 31, 1986 for nonparticipating physicians.

Current law permits the Secretary certain flexibility in determining reasonable charges. Regulations allow the use of "other factors that may be found necessary and appropriate with respect to a specific item or service . . . in judging whether the charge is inherently reasonable." COBRA requires the Secretary to promulgate regulations which specify explicitly the criteria of "inherent reasonableness." HHS issued proposed regulations on February 18,

1986, summarizing the conditions under which the Secretary could use the "inherent reasonableness" authority to establish either special methodologies or specific dollar limits when fees paid under current methods are determined to be inherently unreasonable.

Explanation of provision.—The provision would identify instances where inherent reasonableness limitations could be applied though use of the limitations would not be limited to the identified instances. If the Secretary applies the inherent reasonableness authority, the provision specifies the factors that would be considered in determining the inherent reasonableness of charges. The identified factors would include cases where: prevailing charges are significantly different from those in comparable localities; Medicare and Medicaid are the main sources of payment; the marketplace for the service is not truly competitive because of the limited number of physicians performing the service; there have been increases in charges not explained by inflation; charges do not reflect changing technology or reduction in acquisition or production costs, or the prevailing charges are substantially higher than payments made by other purchasers. The Secretary must review the ten most costly procedures with respect to the aggregate cost to Medicare.

The provision would provide that regional differences in fees would be taken into account unless there is substantial economic justification for a uniform national fee or payment limit. The Secretary would be required to use the rule-making process in any case where he or she proposes to establish a new reasonable charge, or a methodology for a new reasonable charge, based on inherent reasonableness determinations. The notice must include the impact of the change or methodology proposed to be established with respect to changes in the accessibility of, and beneficiary liability for, the service. The provision would require a public comment period and comments by the Physician Payment Review Commission. The provision would require final regulations to explain the factors and the data the Secretary considered in making the final determinations.

The provision would require the Secretary both to develop an index for adjusting relative value scale (RVS) payment levels to reflect justifiable geographic cost differences and to examine a possible adjustment to encourage physicians to locate in medically underserved areas. The provision also would change the date by which the Secretary is to develop an RVS to July 1, 1989 to allow for completion of research currently being funded by HCFA. The provision would require the consolidation of the payment methodology under HCFA's Common Procedures Coding System (HCPCS) and mandate its use for hospital outpatient services.

Effective date.—Applies to final regulations issued after July 1, 1986.

5. Medicare Economic Index for Physicians' Services

Current law.—Prior to 1984, the increase in the prevailing charge level was updated annually. This update has been limited by the Medicare economic index (MEI). Expressed as a maximum allowable percentage increase, this index reflects changes in physicians' operating expenses and earnings levels.

Explanation of provision.—The provision would modify the MEI to account for a historical overstatement of housing costs. A “rental equivalence” component would be substituted for the housing “home ownership component” of the Consumer Price Index (CPI). This proposed change is patterned after a comparable change made in the CPI in 1983. The provision would adjust the MEI retroactively to 1973, the base year for the MEI.

The provision would provide that the adjustment of the MEI would be made in two stages with one-half of the adjustment becoming effective January 1, 1987, and the other half January 1, 1988. The provision would require the Secretary to utilize the rule-making process for proposed changes in the methodology, basis, or elements of the MEI.

Effective date.—January 1, 1987.

6. End-stage Renal Disease Payments

Current law.—Under the end-stage renal disease (ESRD) program, patients with kidney failure can receive dialysis treatments and physician care. For these services, Medicare will pay:

(a) to a dialysis facility, a so-called “composite rate” for routine kidney dialysis performed on an outpatient basis; and

(b) to a renal physician, a predetermined amount per patient per month for physician services. This amount is called the “monthly capitation payment” (MCP).

Explanation of provision.—The provision would modify the physician payment rates as set forth in the notice in the Federal Register of July 2, 1986. The current methodology used to compute the MCP reflects an assumption that physicians care for 10 patients who dialyze at home for every 7 patients that are dialyzed in a facility during a given period of time. This is a ratio of 10:7.

Based on a recent General Accounting Office study of actual physician services furnished, that ratio would be reduced from 10:7 to about 4:1. As a result of correcting the ratio, the average MCP rate would be reduced from approximately \$187 to \$173 per patient per month.

In addition, this provision would reduce the current renal facility rates by \$1.00 rather than by \$11.00 as proposed by the Administration. The provision would require an independent study of the appropriateness of the facility rate to be completed within one year by the General Accounting Office.

Effective date.—August 1, 1986 for physicians payments; and for facilities October 1, 1986 through September 30, 1988.

7. Payments for Ambulatory Surgery

Current law.—The Omnibus Reconciliation Act of 1980 (P.L. 96-499) authorized payments for facility services furnished in connection with ambulatory surgical procedures specified by the Secretary of Health and Human Services (HHS). Payments are made on the basis of prospectively set known rates as the “standard overhead amounts.”

HHS issued final regulations and an accompanying notice, August 5, 1982, identifying four groups of surgical procedures and the payment amount for each group. The payment amounts and the list of procedures have not been updated. The rates do not in-

clude payments for physicians' services, prosthetic devices, or laboratory services.

No beneficiary cost-sharing is required in connection with services provided in ambulatory surgical centers.

Explanation of provision.—The provision would extend the ambulatory surgical center (ASC) prospective payment approach to hospital outpatient department (OPD) surgery. For all surgeries approved for performance in an ASC, Medicare-participating hospitals would receive the lesser of (a) Medicare's reasonable costs for surgery minus 20 percent of the actual charge, or (b) Medicare's prospective rate for ASC's minus 20 percent of that rate. The provision would be effective for hospital accounting years that begin on or after July 1, 1987.

The provision would require the Secretary, no later than July 1, 1987, to update the 1982 ASC rates that are currently in use. Thereafter, the Secretary annually would review the ASC and OPD rates and revise the list of procedures which are approved for ASC performance and reimbursement.

The provision would impose the standard part B coinsurance (20 percent) and deductible (\$75) for ambulatory surgery services.

Utilizing the HCPCS data that will be available after July 1, 1987, the Secretary would be required to: (a) develop packages of pre- and post-operative services for different procedures that are appropriate for application of a prospective payment system, and (b) develop a PPS methodology for all outpatient procedures. The Secretary would be required to report to Congress on these packages and the PPS methodology by January 1, 1991.

For contracts entered into or renewed after January 1, 1987, the Secretary would be required to add to each Utilization and Quality Control Peer Review Organization (PRO) scope of work the requirement that PROs review the medical necessity and quality of surgery in OPD and ASC settings. The percentage of cases to be reviewed, and whether there is to be pre- and post-procedure review, is left to the Secretary's discretion. Payments for the cost of outpatient certified registered nurse anesthetist (CRNA) services and direct medical education would continue to be made as under current law. The Secretary would be required to conduct a two-year study on educational activities in hospital outpatient settings and report back to Congress with recommendations about a proper payment for graduate medical education (GME) related to outpatient hospital services.

Effective date.—July 1, 1987.

8. Payment of Medicare Claims

Current law.—Hospitals, skilled nursing facilities and home health agencies who meet certain requirements may receive Medicare periodic interim payments (PIP) every two weeks, based on estimated annual costs without regard to the submission of individual bills. At the end of the year, a settlement is made so that the provider receives the actual payment amounts for treating Medicare beneficiaries. In proposed fiscal year 1987 regulations for the prospective payment system (PPS), the Department of Health and Human Services proposed to end PIP for most PPS and PPS-

exempt hospitals, effective July 1, 1987, except in the event a beneficiary is an inpatient for more than 45 Medicare-covered days.

The Health Care Financing Administration (HCFA) recently issued guidelines requiring each part A intermediary and part B carrier to process at least 95 percent of "clean" Medicare claims within 27 days of receipt. "Clean" Medicare claims are those not requiring development for payment safeguard activities or additional information. The guidelines apply to Medicare claims submitted by beneficiaries, physicians, providers, and suppliers of health care.

Explanation of provision.—The provision would eliminate periodic interim payments for all PPS hospitals. Qualified non-PPS hospitals, skilled nursing facilities, and home health agencies (all of which are paid on the basis of costs) would continue to receive such payments.

The provision also would require each part A intermediary and part B carrier to process and pay at least 95 percent of all "clean" Medicare claims within 24 days of receipt. The 24 day limit would be a ceiling. Providers who received payments during the first half of 1986 for their clean Medicare claims within a shorter time period should not have their payments delayed beyond the claims processing time frames they experienced during the first six months of 1986 in order to meet the requirements of this provision. The committee intends that the 24-day standard be applied without differentiation between electronically transmitted and conventional "paper" claims.

The elimination of PIP for PPS hospitals would be delayed until an intermediary had demonstrated that it had complied with the prompt payment provision for at least three consecutive months. The Committee intends that the Secretary would establish, on a temporary basis, interim payments during any period in which claims processing is suspended. If an intermediary fails to meet the prompt payment criterion for three consecutive months, all the hospitals it serves may choose to be placed on PIP. Once an intermediary has reestablished compliance with the prompt payment rule for three consecutive months, the reinstatement of PIP would be discontinued.

If the carrier fails to pay 95 percent of clean part B claims within 24 days, interest will be assessed on delayed claims for each day beginning with the 25th day (at the usual government prompt payment rate) until the claim is paid. To allow time for carriers to develop new processing systems, the interest requirement would be delayed 6 months and there would be a 15-day grace period (i.e., the penalties would only be applied to claims on or after the 40th day) for one year.

Effective date.—October 1, 1986.

9. Changes in Inpatient Hospital Deductible

Current law.—Medicare's inpatient hospital deductible must, by law, be adjusted each January based on a formula which reflects the average cost of a day of hospital care.

In recent years lengths of stay have been decreasing faster than costs per stay. Total costs now are divided by a smaller denominator; this results in a higher per-day figure. The deductible was \$400

in 1985, and is \$492 in 1986. The Administration estimates that the deductible will increase by 16 percent to \$572 in 1987.

Explanation of provision.—This provision would set the deductible at \$520 in 1987. In future years, the annual increase in the deductible would be tied to the annual increase in the average cost of a Medicare hospital discharge instead of the cost of an average day of hospital care.

Effective date.—January 1, 1987.

10. Provider Representation of Beneficiaries on Appeals

Current law.—In 1984, manual instructions prohibited providers (e.g., hospitals and home health agencies) from representing a beneficiary in an appeal where a payment had been denied for a service they provided.

Explanation of provision.—The provision would broaden the appeal authority to include provider representation of beneficiaries for all Medicare part A and part B appeals of claims denials. Providers would not be allowed to claim the costs of unsuccessful appeals on the cost report. Beneficiaries would not be responsible for the costs of successful or unsuccessful appeals filed on their behalf.

Effective date.—Enactment.

11. Notice of Hospital Discharge Rights; Discharge Planning

Current law.—Under the Medicare prospective payment system hospitals are reimbursed on a per case basis according to a patient's diagnosis. The payment rates reflect the average cost of providing care for patients in the same diagnostic category. Hospitals and/or physicians determine when it is medically appropriate to discharge a Medicare beneficiary from inpatient care. In February 1986, the Health Care Financing Administration arranged for voluntary distribution to patients through hospitals of a notice of patient rights which includes information concerning financial liability for continued inpatient stay and procedures to appeal a discharge notice.

Beneficiaries who have been in the hospital three days and require additional skilled care are eligible for up to 100 days of care in a Medicare approved skilled nursing facility (SNF). Beneficiaries who must remain at home but still require skilled nursing care on an intermittent basis are eligible for home health services. In May 1986, regulations were issued to require hospitals which participate in Medicare to have a discharge planning program to facilitate the provision of follow-up care after discharge from the hospital. Fiscal intermediaries determine whether claims for these services meet Medicare coverage criteria after a claim has been submitted.

Explanation of provision.—The provision would amend Medicare's conditions of participation for hospitals to require that beneficiaries receive a notice of patient rights at the time of admission to the hospital. The notice would include information concerning rights to inpatient and post-hospital care under Medicare, financial liability, and appeal rights.

The provision would require a hospital, as a condition of participation in Medicare, to provide a timely discharge planning evaluation for beneficiaries that would meet guidelines to be established by the Secretary. The discharge evaluation would assess the pa-

tient's need for post-hospital services and the availability of these services. The Committee intends that the Secretary exercise flexibility in establishing the standards and guidelines for discharge planning so as not to place undue hardship on small hospitals, particularly those in rural areas. In establishing conditions of participation for hospitals not accredited by the Joint Commission on Accreditation of Hospitals, the Secretary did provide flexibility in the discharge planning requirements, including flexibility for the hospital to determine the appropriate personnel to carry out the discharge planning. The Committee expects the Secretary to allow for similar flexibility under the discharge planning requirements of this provision.

The Secretary would be required to implement a pilot program to test prior and concurrent authorization for SNF and home health services as an alternative to the waiver of liability provision. The results of the pilot program would be due to the Congress April 1988.

Effective date.—The notice of patient rights would be required no later than six months after enactment. The discharge planning requirement would be effective one year after the date of enactment.

12. PRO Review of Discharge Appeals

Current law.—If a Medicare beneficiary believes that his or her discharge decision is premature, he or she may appeal to a Utilization and Quality Control Peer Review Organization (PRO). The PRO must make a determination within three working days of receipt of the appeal. In the event of an adverse decision, the beneficiary may be financially liable for several days of continued stay before receiving notice of the PRO's decision.

Explanation of provision.—The PRO would be required to make the appeal decision within two calendar days after receipt of an appeal. A beneficiary who appeals his or her discharge notice and loses the appeal would not be liable for charges for a continued inpatient hospital stay until the day following receipt of the PRO's adverse decision on appeal. This financial protection could apply only up to four days after the discharge notice.

Effective date.—The expedited PRO review of hospital denial notices would be effective 30 days after enactment.

13. PRO Review of Inpatient Hospital Services and Readmissions

Current law.—Utilization and Quality Control Peer Review Organizations (PROs) review cases of all patients that have been readmitted to the same hospital within 15 days of discharge.

Explanation of provision.—Review of cases that have been readmitted to the hospital will include at least a sample of readmissions occurring within 31 days of discharge.

The provision would require the Secretary to take measures needed to ensure that PROs receive necessary patient information. This information should be transmitted directly from the hospital if the fiscal intermediary unnecessarily delays forwarding the data.

Effective date.—Intensified readmission review would apply to PRO contracts entered into or renewed on or after January 1, 1987. The timely data and information sharing requirements would be effective within six months of the date of enactment.

14. PRO Review of Quality of Care

Current law.—Utilization and Quality Control Peer Review Organizations (PROs) are required to review at least a sample of the professional activities of physicians and other health care practitioners and of institutional and noninstitutional providers (including health maintenance organizations and competitive medical plans) for purposes of determining whether the services provided were medically necessary and met professionally recognized standards of care. However, PRO contracts limit required review to inpatient hospital services. PROs are also responsible for assuring confidentiality of patient information.

Explanation of provision.—The provision would require each PRO to devote a reasonable proportion of its efforts to quality of care reviews. In addition, each PRO would be required to provide that a reasonable allocation of its quality of care review activities is made among the different cases and settings (including post-acute care settings, ambulatory settings, and health maintenance organizations) for which potential problems of quality have been identified. The provision would require the Secretary of Health and Human Services to identify methods to assist PROs in identifying those cases which are more likely than others to be associated with quality care problems.

PROs would be required to acknowledge formally all written beneficiary complaints about the quality of Medicare covered services. This acknowledgement would advise the beneficiary that appropriate action would be taken. The PRO will determine the appropriate course of action which may include a formal investigation. The PRO would be expected to establish a process to account for each request and its disposition.

In addition, PROs would be required to share confidential information related to quality of care with state licensing authorities and national accrediting bodies acting pursuant to section 1865 of the Social Security Act.

Effective date.—The provision relative to PRO requirements would apply to PRO contracts entered into or renewed on or after January 1, 1987. The amendment relating to the Secretary's responsibilities to help PROs identify quality problems would be effective on enactment. Beneficiary complaints received nine months after the date of enactment must be acknowledged. PROs are required to share confidential information for requests received six months after enactment.

15. Payment for Home Health Services

Current law.—Under regulations published July 5, 1985, reimbursement for home health services is limited to 120 percent of the mean cost per visit incurred by all home health agencies. For cost reporting periods beginning on or after July 1, 1986 the limits are set at 115 percent of the mean, and for such periods beginning on or after July 1, 1987 the limits are set at 112 percent of the mean. Separate limits are established for and applied to each type of service (e.g., skilled nursing, home health aide, and physical therapy services).

Explanation of provision.—The provision would allow home health agencies to apply the per service limits in the aggregate rather than to each type of home health service. The General Accounting Office would be required to report on the appropriateness of applying the limits on a service-by-service basis.

Effective date.—Cost reporting periods beginning on or after October 1, 1986.

16. Occupational Therapy Services

Current law.—Part B coverage of occupational therapy services is limited to treatment in a hospital outpatient department, comprehensive outpatient rehabilitation facility, home health agency, or when provided incident to physicians' services.

Explanation of provision.—The provision would extend reimbursement under part B of Medicare for occupational therapy services. This therapy would be covered when provided in a skilled nursing facility (when part A coverage is exhausted), in a clinic, or a rehabilitation agency. Payment would be made on a reasonable cost basis.

The provision would provide part B coverage of occupational therapy services when furnished in a therapist's office or a beneficiary's home. The independently practicing therapist would have to meet licensing and other standards prescribed by the Secretary. No more than \$500 in incurred expenses would be eligible for coverage in a calendar year per beneficiary. Payment would be based on 80 percent of reasonable charges.

Effective date.—October 1, 1986.

17. Modify Waiver of Liability and Appeals for Home Health Services

Current law.—Home health agencies can receive payments for items or services which are not deemed reasonable and necessary or are determined to be custodial in nature, if neither the beneficiary nor the provider knew (or could reasonably be expected to have known) that they were not covered. Home health care agencies can be presumed to meet this test if their claims denial rate falls below 2.5 percent. COBRA maintained this favorable presumption criteria for home health agencies until 12 months after claims processing for home health agencies has been consolidated under 10 regional intermediaries (as required by law).

Beneficiaries who are homebound and require (a) skilled nursing services on an intermittent basis or (b) physical or speech therapy are eligible for home health services. Program guidelines specify that intermittent care is care usually provided a few hours a day several times a week. These guidelines also specify that intermittent care can include medically reasonable and necessary daily care (7 days a week) for a short period of time (2-3 weeks) and, in a few cases involving unusual circumstances, an additional period when certified by a physician. The manuals classify denials of coverage under the intermittent or homebound criteria as "technical denials". Technical denials cannot be appealed.

Explanation of provision.—The provision would amend the waiver of liability provision. The provision would allow the payment for home health services if the provider did not or could not

have been expected to know that payment would be denied on the basis that the individual was not homebound or did not require care on an intermittent basis. By removing these coverage criteria from "technical denial" status, all home health service claims could be appealed. The Secretary would be required to issue regulations which specify the limitations that were applied through manuals and guidelines as of January 1, 1986 to be applied to homebound and intermittent status for covered home health services. Final regulations must be published by July 1, 1987.

Effective date.—The expansion of the appeal and waiver of liability provisions would apply to coverage denials occurring after July 1, 1987.

18. Establishment of Patient Outcome Assessment Project

Current law.—No provision.

Explanation of provision.—The Committee is concerned about the wide variation in medical practice patterns throughout the country. The provision would require the Secretary of Health and Human Services to study nationwide variations in medical practice patterns for certain medical procedures. Further, the Secretary would be required to study the relationship between these variations and health status outcomes, with primary emphasis on Medicare beneficiaries.

Effective date.—October 1, 1986.

B. Medicaid Provisions

1. Optional Coverage of Poor Pregnant Women, Infants, and Children

Current law.—States are required to provide Medicaid coverage to all children receiving assistance under the federally assisted Aid to Families with Dependent Children (AFDC) program and may provide coverage for children who would be eligible for AFDC except for income requirements (known as the medically needy). In addition, States may cover all or reasonable categories of children under age 18 or 19 or 20 or 21 who do not meet the AFDC definition of dependent children (known as Ribicoff children). States are required to cover all children born after October 1, 1983 up to age five who meet the AFDC income and resources requirements and may extend coverage to all such children under age five immediately. States are also required to cover pregnant women meeting AFDC income and resources standards. The January 1986 AFDC levels in the 48 contiguous States and the District of Columbia were all below the poverty line.

Explanation of provision.—The provision would give States the option to expand Medicaid eligibility to cover: (1) pregnant women with incomes up to the Federal poverty level; and (2) young children with family incomes up to the Federal poverty level. Initially the States could cover children under age one. Beginning in fiscal year 1988 the age level would increase by one in each fiscal year until all children up to age five were included. Under the provision, States would be permitted, but not required, to impose an assets test for both pregnant women and children equal to that used under the current AFDC, Supplement Security Income (SSI), or the State medically needy program.

The provision would specify that election of expanded Medicaid coverage would be optional with the States. Covered services would include prenatal, delivery, and 60-days of post-partum care services for pregnant women and all Medicaid services for covered children.

The provision is intended to promote reductions in infant mortality and incidence of low birthweight. Accordingly, States will be able to elect to cover women and certain children with incomes up to the poverty line for services that would be designed to achieve these goals.

The Committee believes that to ensure the effectiveness of this provision, States should conduct outreach efforts to insure that potentially eligible women are aware of the availability of this coverage. Without such outreach and care, this amendment might merely result in substitution of Federal funds for State or local funds now spent on hospital-based deliveries without any concomitant reduction in infant mortality or incidence of low birthweight. This provision is not intended to permit States or localities to

reduce their current levels of services to pregnant women and children.

Effective date.—April 1, 1987.

2. Optional Coverage of Elderly and Disabled Poor and Poor Medicare Beneficiaries

Current law.—Eligibility of the elderly and the disabled for Medicaid is linked to actual or potential receipt of cash assistance under the Federal Supplemental Security Income (SSI) program. The elderly and the disabled covered under Medicaid generally are persons receiving Federal and/or State SSI payments, residing in a skilled nursing facility or intermediate care facility, or incurring substantial medical expenses. The income and resources eligibility criteria differ substantially among the States.

Proposal.—The States would have the option to expand Medicaid eligibility to cover the elderly and disabled with an income threshold up to the Federal poverty level for (1) all Medicaid services; or (2) only the cost of the Medicare part A deductible and coinsurance, and the part B premium, deductible, and coinsurance. The resource limit would be the same as under the SSI program for States which restrict coverage to the categorically needy; States having medically needy programs could use the medically needy resource levels.

The provision would provide that election of expanded coverage would be optional with the States. However, the election could only be made where the State had expanded its Medicaid coverage for children up to one year of age and pregnant women as authorized under the Committee bill. States would not be required to use the same income levels for newly eligible children and pregnant women as they use for the newly eligible aged and disabled.

Effective date.—July 1, 1987.

3. Hold-harmless Provision for Change in Federal Medical Assistance Percentage

Current law.—COBRA provided that beginning in fiscal year 1987, the Federal Medical Assistance Percentage (FMAP) is to be calculated on an annual rather than a biennial basis. The FMAP, which represents the Federal share of Medicaid expenditures in the State, is tied to a formula inversely related to the per capita income of the State.

Explanation of provision.—The provision would specify that any State which would be adversely affected in FY 1987 by the change from a biennial to annual calculation of the FMAP, would be permitted to continue to use the FY 1986 matching rate for FY 1987 for Medicaid.

Effective date.—October 1, 1986.

4. Respiratory Care Services for Ventilator-dependent Individuals

Current law.—States are required to cover home health services for Medicaid beneficiaries who are over 21 and categorically needy under 21 if they are eligible to receive skilled nursing facility services. They may also offer such services to the medically needy.

Medicaid will pay for ventilator dependent services in the home only if the State has elected to provide such coverage on a state-

wide basis or if the State is offering the services to a target population group under a home and community-based services waiver.

Explanation of provision.—The provision would require States to cover respiratory services in the home for individuals who (1) are medically dependent on a ventilator for life support at least 6 hours per day; (2) have been so dependent for at least 30 consecutive days (or the maximum number of days authorized under the State plan, whichever is less), as inpatients, and who, but for home respiratory care, would require respiratory care on an inpatient basis paid for by Medicaid in these institutions; (3) have adequate social support services to be cared for at home; and (4) wish to be cared for at home. The requirements under (2) may be satisfied by a continuous stay in any one or more of the following facilities; hospitals, skilled nursing facilities, or intermediate care facilities.

Effective date.—Service performed on or after October 1, 1986.

5. Respite Care Pilot Project in New Jersey

Current law.—Medicaid does not currently cover respite care services except where provided under a home- and community-based services waiver.

Explanation of provision.—The provision would fund a respite care project in the State of New Jersey now operated by the New Jersey Department of Health. All families would be eligible for the project but priority would be given to Medicaid recipients, with others paying on a sliding scale for services. Highest priority will go to elderly beneficiaries who will become Medicaid eligible if they become institutionalized. Half of the funding for the respite care program would come from the State and half from Medicaid. In no case will Federal outlays exceed \$1,000,000 in FY1987, and \$2,000,000 in each of FYs 1988, 1989, and 1990. Federal funding will cease to be available after September 30, 1990.

Effective date.—Enactment.

6. Presumption of Eligibility for Pregnant Women

Current law.—Title XIX of the Social Security Act allows for a three month retroactive eligibility period prior to the date on which application for medical assistance is made. Medicaid regulations further require State agencies to determine eligibility within 45 days from the day of the application for benefits. If the application is approved, medical expenses incurred during those 45 days would be reimbursed under the normal Medicaid rules. If the application is denied, medical expenses incurred during those 45 days would be the responsibility of the individual.

Explanation of provision.—The provision would permit State agencies to accelerate Medicaid eligibility for ambulatory prenatal care. Under the program, the agency may for any one pregnancy, grant presumptive eligibility for a period not to exceed 45 days if: (1) the woman has begun maternity care with a qualified Medicaid provider eligible to participate in the presumptive eligibility program; (2) the provider determines that the woman's family income falls below the applicable Medicaid standard; (3) the provider notifies the State agency within 5 working days of the woman's eligibility; and (4) the individual applies for program benefits within 14

calendar days of the beginning date of the presumed eligibility period.

A qualified Medicaid provider for purposes of this provision is an organization which provides outpatient hospital, rural health, or Medicaid clinic services as defined under Title XIX of the Social Security Act. In addition, the provider must be receiving funding from certain other Federal programs or be a State-approved perinatal clinic.

States must provide guidelines to these clinics on how to determine this presumptive Medicaid eligibility. Clinics that do not perform this eligibility function to the satisfaction of the State can be barred from participating from this presumptive eligibility program.

Federal medical assistance payments made on behalf of pregnant women during the accelerated eligibility period would be at the same rate applicable for other beneficiaries in the State regardless of whether such women are ultimately determined to be eligible for medical assistance.

State agencies would be responsible for processing the normal application for benefits. This application would include all the information otherwise required for all State Medicaid applicants, such as third party liability information, social security number, establishment of paternity, assignment of rights to payments, and all information related to income and resources.

Effective date.—April 1, 1987.

C. Miscellaneous Provisions

1. Retroactive Modification of Child Support Arrearages

Current law.—In most States, a child support order can be modified only prospectively; that is, the terms of the modification do not take effect until after the date on which it becomes final. Thus, only future child support payments would be affected. However, a number of States permit the child support award to be retroactively modified. In such States, the court (or administrative entity) has the authority to reduce or nullify arrearages. Further, under the Uniform Reciprocal Enforcement of Support Act (URESA), in interstate cases, the court in the noncustodial parent's State may modify the child support order of the custodial parent's State to the same extent the order could be modified in the State that issued the order.

Explanation of provision.—The provision adds to the child support enforcement program established by title IV of the Social Security Act a new requirement which States must meet to be in compliance with that program. To meet this new requirement, State laws relating to the enforcement of child support orders must prohibit changes in those orders which are effective on a retroactive basis. The Committee recognizes that a person's financial circumstances change. The noncustodial parent may lose his or her job or face other circumstances that cause him or her not to be able to afford the original child support award. The amendment is not intended to prevent changes in future child support payments if the financial situation of the noncustodial parent changes. What the Committee is seeking to prevent is the purposeful noncompliance by the noncustodial parent, because of his hope that his child support obligation will be retroactively forgiven. If the noncustodial parent's circumstances change because of unemployment, illness or another such reason, the amendment puts the burden on the noncustodial parent to notify the custodial parent and the court or entity which issued the child support order of his changed circumstances and his intent to have his child support order modified. No modification would be permitted before the date of this notification.

2. Hold-harmless Provision for Change in Federal Medical Assistance Percentage for Purposes of the AFDC Program

Current law.—COBRA provided that beginning in fiscal year 1987, the Federal Medical Assistance Percentage (FMAP) is to be calculated on an annual rather than a biennial basis. The FMAP is tied to a formula inversely related to the per capita income of the State. The FMAP may also be used for AFDC.

Explanation of provisions.—The provision would specify that any State which would be adversely affected in FY 1987 by the change

from a biennial to annual calculation of the FMAP, would be permitted to continue to use the FY1986 matching rate for FY1987 for AFDC.

Effective date.—October 1, 1986.

TITLE VI-A: REVENUE PROVISIONS

1. Extend Medicare Coverage and Hospital Insurance Tax to All State and Local Government Employees (sec. 661 of the bill)

Present law.—Prior to enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), P.L. 99-272, State and local government employees were covered for social security and Medicare benefits only if the State and the Secretary of Health and Human Services (HHS) entered into a voluntary agreement providing such coverage. In COBRA, the Congress extended Medicare coverage (and the corresponding hospital insurance payroll tax) on a mandatory basis to State and local government employees hired after March 31, 1986, for services performed after that date.

COBRA also authorized States to elect to extend Medicare coverage to State and local government employees hired prior to April 1, 1986, by voluntary agreement with HHS. Under present law, however, Medicare coverage is not mandatory for State and local government employees hired prior to April 1, 1986 unless such a voluntary agreement is in effect. Medicare coverage (and the hospital insurance payroll tax) is mandatory for Federal employees.

For wages paid in 1986 to Medicare-covered employees, the combined employer-employee hospital insurance tax rate is 2.9 percent (1.45 percent on each) of the first \$42,000 of wages (Code secs. 3101, 3111, and 3121(a)).

Reasons for change.—Individuals who have worked in State and local government employment that is excluded from Medicare coverage often qualify for Medicare benefits. These individuals qualify as a result of work performed in other employment covered under the program or through the entitlement of a spouse. By and large, individuals who qualify after having worked in excluded State and local government employment have contributed significantly less in FICA payroll taxes than others who become entitled to benefits having had comparable lifetime earnings all of which were subject to FICA. Such individuals thus represent an inequitable financial drain on the Medicare hospital insurance program.

Unlike monthly social security benefits, where minimal covered earnings and tax contributions result in minimal benefit amounts, entitlement to Medicare is entitlement for the full range of benefits. The benefits are the same regardless of whether the insured worker has made significant tax contributions over his or her working lifetime or whether the individual has qualified with the minimum number of quarters of coverage. The committee believes that this anomaly should be corrected.

Explanation of provision.—The provision extends hospital insurance (Medicare) coverage on a mandatory basis to all employees of State and local governments not otherwise covered for Medicare

under present law.¹ The employers and their employees will become liable for the hospital insurance portion of the FICA tax, and the employees will earn credit toward Medicare eligibility based on their covered earnings.² (The optional Medicare coverage provision enacted in COBRA is terminated.) The collection of the hospital insurance tax with respect to State and local government employees to whom the provision applies is to be carried out in the same manner as provided in COBRA with respect to employees hired after March 31, 1986.

Effective date.—Medicare coverage and the corresponding hospital insurance payroll tax are extended to all State and local employees (not otherwise covered by present law) effective after April 30, 1987, for services performed after that date.

2. Increase in Cigarette Excise Tax Rates (sec. 662 of the bill)

Present law.—An excise tax is imposed on cigarettes manufactured in or imported into the United States (Code sec. 5701). In COBRA, the Congress made permanent the tax rate on small cigarettes at \$8 per thousand (i.e., 16 cents per pack of 20 cigarettes), and the tax on large cigarettes at \$16.80 per thousand. (Proportionately higher rates apply to large cigarettes that exceed 6.5 inches in length.) Most cigarettes are classified as small cigarettes (i.e., weigh not more than three pounds per thousand) and thus are taxable at 16 cents per pack.

Reasons for change.—The committee determined that the present budgetary situation requires an increase in cigarette excise tax rates. The committee further believes that an increase in cigarette taxes should help to discourage smoking, particularly among younger Americans, and reduce associated health risks.

The committee took into consideration that cigarette excise tax rates were unchanged between 1951 and 1982. Because the tax is imposed at a flat rate, rather than as a percentage of sale price, the effective rate of the tax declined steadily during this period. Even with the increase made by the bill, the tax rate will remain lower than it would have been had the 1951 tax rate been indexed for changes since 1951 in the consumer price index.

Explanation of provision.—The bill increases the excise tax rate on small cigarettes to \$12 per thousand (i.e., from 16 to 24 cents per pack of 20 cigarettes). Large cigarettes not exceeding 6.5 inches in length are to be taxed at a rate of \$25.20 per thousand; proportionate increases apply for large cigarettes that exceed 6.5 inches in length.

¹ As under present law, Medicare coverage and the hospital insurance tax are not extended to individuals hired by a State or political subdivision to relieve unemployment; patients or inmates working in a hospital, home, or other institution; temporary State or local government workers hired for certain emergencies; or certain students working in District of Columbia hospitals. Also, the provision extends for Medicare coverage purposes the present-law exception, applicable under social security and Medicare coverage pursuant to voluntary State agreements, for certain election officials and election workers who are paid less than \$100 in a calendar year (see 42 U.S.C. sec. 418(c)(8)).

² Also, employees who performed service for a State or local government before May 1, 1987 that would constitute Medicare-qualified government employment if performed after May 1, 1987 may receive credit, for Medicare coverage purposes only, for such prior service under transitional provisions in the bill, similar to transitional provisions enacted when mandatory Medicare coverage was extended to Federal employees. The bill includes a provision authorizing appropriations as required for the transitional provision.

As in the case of the 1982 rate increase, the increased rates under the bill apply to certain cigarette floor stocks. Under the bill, an additional tax is imposed on each person holding cigarettes for sale (other than certain retail stocks) on October 1, 1986, if the cigarettes were removed from bonded premises before that date and taxes were paid on removal at the present-law rates. The additional tax (which is treated as a tax imposed under sec. 5701) equals the excess of the tax that would apply to removal of the cigarettes from bonded premises on or after October 1, 1986, over the present-law tax rates on such cigarettes (e.g., the additional tax on small cigarettes is \$4 per thousand). This additional tax is due and payable on November 17, 1986.

The bill expressly provides that cigarettes that are held in a foreign trade zone on October 1, 1986 and that are entered into the customs territory of the United States on or after October 1, 1986 are treated as held for sale on October 1, 1986 and are subject to the floor stocks tax. This includes both foreign articles on which taxes have been determined or customs duties liquidated by a customs officer at the present-law rate, and also domestic articles as to which tax liability has attached at the present-law rate and which have been placed under supervision of a customs officer, if such foreign or domestic articles are held in a foreign trade zone on October 1, 1986 and are entered or re-entered into the customs territory of the United States on or after October 1, 1986.

An exemption from the floor stocks tax is provided only for cigarettes held for sale by a retailer on October 1, 1986 at the place where intended to be sold at retail. For example, cigarettes held for sale on October 1, 1986 on the shelves of a retail store will be exempt as held by a retailer, but cigarettes held on October 1, 1986 in warehouses or other similar facilities where retail consumers do not have regular access to them or in a foreign trade zone are not to be treated as retail stocks held by a retailer and hence are not eligible for the exemption.

Effective date.—The provision is effective for cigarettes removed from bonded premises after September 30, 1986, and for floor stocks (other than exempted retail floor stocks) held or treated as held on October 1, 1986.

ADDITIONAL VIEWS OF SENATOR WILLIAM ARMSTRONG ON THE MEDICARE TAX ON STATE AND LOCAL EMPLOYEES

Earlier this year, Congress imposed the Medicare Hospital Insurance payroll tax on State and local employees hired after March 31, 1986—that is, on newly hired workers. It was the judgment of Congress last fall that such a significant tax on State government and workers should be phased-in prospectively. I believe this was the appropriate way to handle the imposition of the tax and do not support imposing it on current State and local employees as proposed in this reconciliation bill.

I recognize that many State and local employees become eligible for Medicare benefits through private sector employment, or through a spouse, and as a result receive full benefits while paying a lesser amount in Medicare taxes than a private sector employee. In my view, this inequity was addressed last year in an equitable manner by phasing in the new tax. There is about a 9% turnover rate each year among State and local employees. Thus, over a relatively short period of time, all State and local workers will be required to pay into Medicare.

I think this solution is far preferable to imposing a direct 1.45% pay cut on current State and local workers and requiring State governments as employers to pay an equal tax. I am concerned this proposal will seriously undermine financial stability of existing State supported retirement and health care programs. In addition, some State treasuries are already suffering from the problems facing the oil and farm industries. In recent years, States have also faced limitations on direct Federal aid from Congress. While reductions in such Federal aid are justified because of the Federal deficit, I do not believe Congress should, at the same time, ask State governments to pay more from their own treasuries in taxes to Washington.



CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

CBO COST ESTIMATE

Rudolph G. Penner
Director

July 29, 1986

Honorable Bob Packwood
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The Congressional Budget Office has prepared the attached cost estimates of the provisions in the Senate Committee on Finance's reconciliation package. Provisions with no outlay or revenue effect are not listed in the tables. The estimates are shown in two separate attachments--one showing estimated outlay effects and one showing estimated revenue effects.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

A handwritten signature in dark ink, appearing to read 'Rudy Penner', with a long horizontal flourish extending to the right.

Rudolph G. Penner

cc: Honorable Russell B. Long
Ranking Minority Member

TABLE 1. THE ESTIMATED REVENUE EFFECTS OF THE SENATE FINANCE COMMITTEE RECONCILIATION PROVISIONS RELATIVE TO THE BUDGET RESOLUTION BASE (Fiscal years, in billions of dollars)

	1987	1988	1989	3-Year Total
Increase cigarette excise tax by 8 cents per pack, net ^a	1.593	1.684	1.693	4.970
Extend Medicare coverage to state and local government employees hired prior to April 1, 1986 ^b	0.829	2.151	2.169	5.149
Total Revenue Effect, Net	2.422	3.835	3.862	10.119

a. Effective October 1, 1986.

b. Effective May 1, 1987.

Congressional Budget Office
Tax Analysis Division
July 28, 1986

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TABLE 2 -
FINANCE RECONCILIATION PROVISIONS
IN MILLIONS OF DOLLARS

SUBTITLE A -- OUTLAY PROVISIONS

Part 1 -- Provisions Relating to the Medicare Program

SECTIONS -----		FY 1987 -----	FY 1988 -----	FY 1989 -----	3-YEAR TOTAL -----
Subpart A -- Provisions Relating to Part A of Medicare					
601 - Payments for Inpatient Hospital Services **					
	BA	10	30	55	95
	0	-180	-230	-260	-670
602 - Payments for Capital Related Costs					
	BA	5	15	40	60
	0	-75	-205	-310	-590
603 - Changes in Inpatient Hospital Deductible					
	BA	-40	-105	-175	-320
	0	420	660	630	1710
604 - Requiring Notice of Hospital Discharge Rights					
	BA	0	-1	-1	-2
	0	3	5	7	15
SUBTOTAL FOR SUBPART A --	BA	-25	-61	-81	-167
	0	168	230	67	465
Subpart B -- Provisions Relating To Parts A and B of Medicare					
611 - Medicare Coverage as Secondary Payor					
	BA	-40	-36	-12	-88
	0	-255	-340	-370	-965
612 - Payment of Medicare Claims					
	BA	615	360	375	1350
	0	-2140	-185	-245	-2570
613 - Payment For Home Health Services					
	BA	-1	-2	-5	-8
	0	15	15	20	50
614 - Modifications of Waiver of Liability and Appeal Provisions for Home Health Services					
	BA	-2	-5	-10	-17
	0	40	45	50	135
615 - Provider Representation of Beneficiaries on Appeals					
	BA	0	-1	-1	-2
	0	4	7	7	18

SECTIONS -----		FY 1987 -----	FY 1988 -----	FY 1989 -----	3-YEAR TOTAL -----
616 - Establishment of Patient Outcomes Project					
	BA	0	-1	-2	-3
	0	5	7	8	20
SUBTOTAL SUBPART B -	BA	572	315	345	1232
	0	-2331	-451	-530	-3312
Subpart C -- Provisions relating to Part B of Medicare					
621 - Payments for Physician Services					
	BA	-105	-110	-125	-340
	0	-100	-105	-120	-325
622 - MEI for Physicians Services					
	BA	-85	-215	-260	-560
	0	-50	-200	-250	-500
623 - End Stage Renal Disease Payments					
	BA	-32	-32	-32	-96
	0	-30	-30	-30	-90
624 - Payments for Ambulatory Surgery					
	BA	-55	-95	-125	-275
	0	-45	-85	-120	-250
625 - Occupational Therapy Services					
	BA	15	16	20	51
	0	15	15	20	50
SUBTOTAL SUBPART C -	BA	-262	-436	-522	-1220
	0	-210	-405	-500	-1115
Subpart D -- Peer Review Organizations					
631 - PRO Review of Hospital Denial Notices					
	BA	0	0	0	0
	0	1	2	2	5
632 - PRO Review of Inpatient Hospital Services					
	BA	0	0	-1	-1
	0	2	3	3	8
633 - Requiring PRO Review of Quality of Care Services					
	BA	0	0	0	0
	0	1	2	2	5
SUBTOTAL SUBPART D -	BA	0	0	-1	-1
	0	4	7	7	18
SUBTOTAL MEDICARE PROVISIONS	BA	285	-182	-259	-156
	0	-2369	-619	-956	-3944

** Estimate pending final legislative language

Part 2 -- Provisions Relating to the Medicaid Program

SECTIONS		FY 1987	FY 1988	FY 1989	3-YEAR TOTAL
641 - Optional Coverage of Pregnant Women and Infants					
	BA	25	85	110	220
	0	25	85	110	220
642 - Optional Coverage of Elderly and Disabled					
	BA	45	170	240	455
	0	45	170	240	455
643 - Respiratory Care Services					
	BA	-2	0	0	-2
	0	-2	0	0	-2
644 - Hold-harmless for Medicaid Matching Percentage					
	BA	50	0	0	50
	0	50	0	0	50
645 - Respite Care Pilot Project					
	BA	1	2	2	5
	0	1	2	2	5
646 - Presumptive Eligibility					
	BA	2	2	2	6
	0	2	2	2	6
SUBTOTAL MEDICAID PROVISIONS	BA	121	259	354	734
	0	121	259	354	734

Part 3 -- Miscellaneous Provisions

651 - Procedure to Prohibit Retroactive Modification of Child Support Payments					
	BA	-1	-2	-3	-6
	0	-1	-2	-3	-6
651 - Hold-harmless for AFDC Matching Percentage					
	BA	15	0	0	15
	0	15	0	0	15
SUBTOTAL MISC. PROVISIONS	BA	14	-2	-3	9
	0	14	-2	-3	9

OFFSET TO REVENUE PROVISIONS

Additional Medicare Expenditures

As A Result of State and Local Coverage

	BA	0	0	0	0
	0	0	2	6	8
SUBTOTAL ALL OUTLAY PROVISIONS					
	BA	420	75	92	587
	0	-2234	-360	-599	-3193

ADDITIONAL VIEWS OF SENATOR GEORGE J. MITCHELL, RECONCILIATION ACT OF 1986

I cannot support the recommendations of the Finance Committee to meet its reconciliation instructions because, once again, the Committee is relying on regressive excise and payroll taxes to reduce federal budget deficits.

Too often over the last few years, Congress has turned to taxes which are not based on ability to pay as a means of meeting budget reconciliation instructions for deficit reduction.

As a result, federal excise, payroll, and use taxes are contributing a growing share of federal revenues, causing a redistribution of tax burdens away from upper income families and toward middle and low income earners. In 1982, 1983, 1984 and again earlier this year, Congress enacted legislation increasing the payroll tax and almost every excise tax while creating new use fees.

Unfortunately, it appears that this trend toward greater reliance on taxes which are not based on ability to pay will continue. This is the second budget reconciliation measure we have considered during 1986. The measure enacted earlier this year increased federal revenues by \$6 billion over a three year period, almost all it from excise and payroll taxes.

In this reconciliation measure the Finance Committee is proposing to raise another \$10 billion over three years, all of which would be raised from higher payroll and excise taxes.

As we consider this budget measure, House and Senate conferees are meeting to finalize an income tax reform measure that will reduce individual income taxes between \$100 billion and \$140 billion over the next five years. After 18 months of consideration of income tax reform, Congress is not likely to turn to the income tax system again. Yet, it is likely that in September Congress will once again have to look for more revenues to meet the Gramm-Rudman budget targets. As a result, Congress will vote still more increases in excise and fixed taxes not related to ability to pay, even as we reduce individual income taxes which are based on ability to pay.

This continuing redistribution of tax burdens on to lower and middle income earners is neither fiscally nor socially responsible. It should be stopped.

OIL POLLUTION LIABILITY AND COMPENSATION ACT OF
1986

SEPTEMBER 23 (legislative day, SEPTEMBER 15), 1986.—Ordered to be printed

Mr. STAFFORD, from the Committee on Environment and Public
Works, submitted the following

REPORT

[To accompany S. 2799]

[Including cost estimate of the Congressional Budget Office]

The Committee on Environment and Public Works, to which was referred the bill (S. 2799) to consolidate and improve Federal laws providing compensation and establishing liability for oil spills having considered the same, reports favorably thereon with amendment and recommends that the bill as amended do pass.

GENERAL STATEMENT

The Committee on Environment and Public Works has long been concerned with the potential environmental dangers posed by the transportation, storage, and handling of oil. In 1970, extensive committee activity resulted in enactment of the Water Quality Improvement Act, which amended the Clean Water Act to establish liability for cleanup of spills of oil from facilities and vessels.

The oil pollution liability provision, section 311, was amended in 1977 to expand the geographic coverage of the law, raise the limits of liability for discharges of oil and hazardous substances, and add restoration of damaged natural resources as an element of removal costs.

In 1978, the committee approved a bill, S. 2083, the Oil Pollution Liability and Compensation Act of 1978, to establish a liability fund and to provide for compensation for damages and cleanup costs caused by discharges of oil and hazardous substances. That portion of the bill regarding hazardous substances was modified and led to enactment of the Comprehensive Environmental Re-

No material re Social Security in this report.

PROVIDING FOR RECONCILIATION PURSU-
ANT TO SECTION 2 OF THE CONCURRENT
RESOLUTION ON THE BUDGET FOR
FISCAL YEAR 1987

CONFERENCE REPORT

TO ACCOMPANY

H.R. 5300



OCTOBER 17, 1986.—Ordered to be printed

OMNIBUS BUDGET RECONCILIATION ACT OF 1986

OCTOBER 17, 1986.—Ordered to be printed

Mr. GRAY of Pennsylvania, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 5300]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 5300) to provide for reconciliation pursuant to section 2 of the concurrent resolution on the budget for fiscal year 1987, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) *SHORT TITLE.*—This Act may be cited as the “Omnibus Budget Reconciliation Act of 1986”.

(b) *TABLE OF CONTENTS.*—

Title I. Agriculture programs.

Title II. Banking and housing programs.

Title III. Energy and environmental programs.

Title IV. Transportation and related programs.

Title V. Maritime programs.

Title VI. Civil service, Postal Service, and governmental affairs generally.

Title VII. Fiscal procedures.

Title VIII. Revenues, trade, and related programs.

Title IX. Income security, medicare, medicaid, and maternal and child health programs.

FOOD FOR PEACE FUNDS

Senate amendment

Section 1106 of the Senate amendment provided that funds made available by Title IV of the Agriculture, Rural Development, and Related Agencies Appropriations Act of 1986 for Public Law 480, Title II programs, and not otherwise obligated, shall be obligated during fiscal year 1986 for the purpose for which they were made available only.

House bill

The House bill contained no comparable provision.

Conference agreement

The Senate recedes to the House.

TITLE VIII—REVENUES, TRADE, AND RELATED PROGRAMS

APPROPRIATIONS FOR IRS ENFORCEMENT

House bill

Section 11002 of the House bill provided that, for purposes of reconciliation, in order to provide for an accurate estimate of revenue raised by increased appropriations for the Internal Revenue Service, the enacted appropriations measure providing funding for the IRS for fiscal year 1987 would include specified levels of funding for the functions of the IRS. Section 11002 further provided for an increase in the allocation to the Senate Committee on Appropriations pursuant to section 302(a) of the Budget Act of \$300,000,000 in both budget authority and outlays for fiscal year 1987.

Senate amendment

Section 665 of the Senate amendment contained a similar provision, specifying levels of funding identical to those in the House bill which would be included in the conference agreement on the appropriations measure providing funding for the IRS.

Conference agreement

The Senate recedes to the House position.

TITLES VIII AND IX—REVENUES, TRADE, AND RELATED PROGRAMS; INCOME SECURITY, MEDICARE, MEDICAID, AND MATERIAL AND CHILD HEALTH PROGRAMS

I. INCOME SECURITY PROVISIONS

1. ELIMINATION OF 3-PERCENT TRIGGER FOR COST-OF-LIVING INCREASES
(SECTION 10001 OF THE HOUSE BILL)*Present law*

The Social Security Act provides for a cost-of-living adjustment (COLA) for benefits under the Old-Age, Survivors, and Disability Insurance Program, based on the consumer price index (CPI), if the CPI increases by 3.0 percent or more during a specified base period (currently, the third quarter of the prior year through the third

quarter of the current year). If the CPI rises by less than 3.0 percent during the base period, a COLA is not provided. In the following year, however, the COLA is based on the accumulated increase in the CPI over 2 years.

Several other automatic increase provisions are linked to the social security COLA, and are triggered only if the social security COLA is provided. These include the increase in: a) the maximum amount of earnings taxable under FICA and SECA; b) the amount of earnings exempt from the retirement test; c) the Supplementary Medical Insurance (SMI) beneficiary premium; d) railroad retirement, Supplemental Security Income (SSI), and Veteran's pension benefits; and e) certain eligibility standards for medicaid, food stamps, housing assistance, and Aid to Families with Dependent Children (AFDC).

House bill

Eliminates the 3-percent trigger for the provision of the social security COLA effective in December 1986. A COLA would be provided in any year in which there has been a measurable increase in the CPI during the specified base period. This would have the effect of assuring that the other automatic increase provisions linked to the Social Security COLA would also rise in any year in which the CPI rises.

Provides technical clarification for the implementation of the SMI "hold harmless" (mandated by the Deficit Reduction Act of 1984) to assure that the proceeds from rounding social security benefit amounts down to the next lower dollar accrue to the OASDI trust funds.

Effective date.—Date of enactment.

Senate amendment

Similar provision.

Conference agreement

The conference agreement follows the House bill.

2. DISINVESTMENT OF SOCIAL SECURITY TRUST FUNDS

Present law

The Old-Age, Survivors, and Disability Insurance (OASDI) program is financed primarily from Social Security taxes on employers, employees, and self-employed persons. Under the normalized tax transfer provisions of current law, the Treasury Department is required at the start of each month to credit the trust funds with an amount equal to the taxes expected to be received during the month. The Treasury Department is also required to invest the assets of the trust funds. Funds must be invested in securities issued (or fully guaranteed) by the Federal Government. The securities issued at the beginning of the month are redeemed as necessary to finance benefit payments. Funds not needed to finance current withdrawals are held by the trust funds in the form of invested assets.

Governmental securities issued to the trust funds are subject to the statutory limit on the public debt. When that debt limit is

reached, the Treasury Department may be unable, without violating the limit, to meet the requirement that an amount equal to expected payroll tax receipt be fully invested at the beginning of the month.

In a situation where the debt limit prevents the Treasury Department from utilizing the normal investment and disinvestment procedures, present law does not provide specific guidance as to the alternative procedures to be followed. On several occasions in 1984 and 1985 the Treasury responded to such situations by disinvesting securities held by the trust funds that it would not have been necessary to redeem in the absence of the debt limit constraint. This procedure allowed the Treasury to create sufficient borrowing authority to finance current withdrawals without exceeding the debt limit.

In such circumstances, the trust funds may be placed in a position where they will earn less interest than would be the case under normal investment procedures. In addition, the redemption of trust fund holdings to generate cash to meet benefit obligations can result in significant changes in the portfolio of investments held by the funds—changes which would not occur in the absence of a debt limit constraint. Present law contains no mechanism to restore the lost interest or to reconstitute the portfolio of the trust funds.

Present law imposes on the Board of Trustees the duties of:

- Holding the trust funds;
- Meeting and reporting to the Congress at least once a year;
- Reporting immediately if they find the balance in a trust fund to be "unduly small";
- Recommending improvements to better coordinate Social Security and unemployment compensation; and
- Reviewing and recommending changes in trust fund management policies.

House bill

No provision.

Senate amendment

Establishes rules for investment and disinvestment of the Old-Age, Survivors, and Disability Insurance (OASDI) Trust Funds during periods when the normal borrowing operations of the Treasury Department are constrained because of the debt limit:

The Treasury Secretary is directed to redeem securities held by the trust funds that absent the debt ceiling would not need to be redeemed to meet the program's obligations on a timely basis;

The amount of such redemptions cannot be greater than the amount which would be redeemed under normal operating conditions; and

If the trust funds have not been issued securities promptly because of debt limit constraints, those securities must be issued as room develops for investment within the debt limit (but only to the extent that the Treasury Department has actually received the Social Security taxes giving rise to those uninvested amounts).

Provides that, after the normal trust fund investment and disinvestment procedures have been affected by a period of debt limit constraint, the trust funds will be restored fully as soon as the debt limit is increased:

There is appropriated to the trust funds the amount of any interest that would have been earned, but was not, because of the impact of the debt limit;

The portfolio of the trust funds is to be reconstituted by the issuance or reissuance of securities as necessary to leave the funds with the same holdings they would have had but for the impact of the debt limit; and

A special Trustees' Report to the Congress is to be made detailing trust fund operations during any period of debt limit constraint and describing the actions taken to restore the funds after the end of that period.

Revises and clarifies the statutory requirements on the Board of Trustees:

The Treasury Secretary is required to report monthly to the Board of Trustees of the Social Security trust funds on the status of the funds, and is required to notify both the Board and the Congress 15 days prior to the date on which he expects, because of the debt limit, to be unable fully to comply with the transfer or investment requirements of the Act;

Funds appropriated or deposited in the Social Security trust funds are to be available immediately and exclusively for trust fund purposes;

The Board of Trustees will be required to meet twice, rather than once each year; and

The duty of the trustee faithfully to execute the responsibilities imposed on them by the Act is explicitly stated.

Effective July 1, 1990, repeals a provision enacted in 1983 under which the OASDI trust funds are credited on the first day of each month with the Social Security taxes expected to be collected during the month. Instead, the funds will be credited on a daily basis as the taxes are received.

Effective date.—Except as noted above, effective on enactment.

Conference agreement

The conference agreement follows the House bill.

3. AFDC FOR UNEMPLOYED TWO-PARENT FAMILIES (SECTION 10101 OF THE HOUSE BILL)

Present law

(a) *State option.*—States have the option to provide AFDC to financially eligible two-parent families in which the principal earner is "unemployed," defined as working fewer than 100 hours per month.

(b) *Eligibility.*—For eligibility, the law requires that the unemployed parent have worked six or more quarters in any 13-calendar quarter period ending within 1 year before applying for AFDC-UP.

NOTE.—States without AFDC-UP programs are: Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Georgia, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Nevada, New Hampshire,

New Mexico, North Carolina, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, Utah, Virginia and Wyoming. The Virgin Islands and Puerto Rico also do not have AFDC-UP.

House bill

(a) *State option.*—Requires all State AFDC programs to offer coverage to financially eligible two-parent families in which the principal earner is “unemployed,” defined as working fewer than 100 hours per month.

(b) *Eligibility.*—Permits States to substitute for 4 quarters of the 6 quarters of work, fulltime attendance in elementary or secondary school or full-time participation in vocational training, but sets a life-time limit of 4 quarters creditable to vocational training.

Effective date.—January 1, 1988.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

4. TARGETING THE USE OF THE INCOME AND ELIGIBILITY VERIFICATION SYSTEM (SECTION 10102 OF THE HOUSE BILL)

Present law

Section 1137 of the Social Security Act requires that States establish an income and eligibility verification system (IEVS) for certain public assistance programs. Under IEVS, the AFDC, Medicaid, unemployment compensation, Food Stamp and SSI programs must request and make use of IRS unearned income information and quarterly wage information.

The Act requires that the use of such information be targeted to those uses which are most likely to be productive in identifying and preventing ineligibility and incorrect payments.

Current regulations require that information be requested and verified for *all* applicants and recipients within a 30-day time period. Action can be delayed on up to 20 percent of the information items when collateral verification sources must be contacted.

House bill

Clarifies that the system is to be targeted to those uses which are likely to be most productive by adding that no State shall be required to use information obtained through the system to verify the eligibility of all recipients.

Report language calls for a 45-day time period for verification of information received.

Effective date.—On enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

5. ANNUAL CALCULATION OF FEDERAL PERCENTAGE OF AFDC EXPENDITURES (SECTION 1013 OF THE HOUSE BILL, SECTION 652 OF SENATE AMENDMENT)

Present law

Prior to enactment of P.L. 99-272, the Federal percentage was calculated between October 1 and November 1 of each even-numbered year. The percentage applied to the two-year period beginning the following October. P.L. 99-272 requires an annual rather than biennial calculation of the Federal percentage beginning in FY 1987.

The shift from a biennial to an annual calculation of the Federal percentage occurs in the middle of the two-year cycle and results in a loss of funds for 13 states in FY 1987.

NOTE.—According to the Department of Health and Human Services, the States affected are: Arizona, Florida, Georgia, Maine, Minnesota, Missouri, New Hampshire, North Carolina, Ohio, Rhode Island, South Carolina, South Dakota and Virginia.

House bill

For FY 1987 only, restores the biennial calculation of the Federal percentage for States that lost funds in the shift to an annual calculation.

Effective date.—October, 1986.

Senate amendment

Identical provision.

Conference agreement

The conference agreement follows the House bill and the Senate amendment.

6. RETROACTIVE MODIFICATION OF CHILD SUPPORT ARREARAGES
(SECTION 651 OF SENATE AMENDMENT)

Present law

In most States, a child support order can be modified only prospectively; that is, the terms of the modification do not take effect until after the date on which it becomes final. Thus, only future child support payments would be affected. However, a number of States permit the child support award to be retroactively modified. In such States, the court (or administrative entity) has the authority to reduce or nullify arrearages. Further, under the Uniform Reciprocal Enforcement of Support Act (URESA), in interstate cases, the court in the noncustodial parent's State may modify the child support order of the custodial parent's State to the same extent the order could be modified in the State that issued the order.

House bill

No provision.

Senate amendment

Adds to the child support enforcement program established by title IVD of the Social Security Act a new requirement which

States must meet to be in compliance with that program. To meet this new requirement, State laws relating to the enforcement of child support orders must prohibit changes in those orders which are effective on a retroactive basis. If the noncustodial parent's circumstances change because of unemployment, illness or another such reason, the amendment requires notification of the custodial parent and the court or entity which issued the child support order of this changed circumstances and his/her intent to have the child support order modified. No modification would be permitted before the date of this notification.

Effective date.—On enactment.

Conference agreement

Under the conference agreement, the House recedes to the Senate amendment, with an amendment which: (1) permits either parent to apply for modification; (2) clarifies the notice requirements; and (3) makes technical changes.

II. MEDICARE PROVISIONS (PART A)

1. CHANGES IN THE PART A DEDUCTIBLE (SECTION 10201 OF HOUSE BILL; SECTION 603 OF SENATE AMENDMENT)

Present law

Medicare's inpatient hospital deductible must, by law, be revised each January. The deductible is revised based on a formula which reflects the average cost of a day of hospital care. The deductible was \$400 in 1985, and is \$492 in 1986. The Administration estimates that the deductible will increase to \$572 in 1987.

The deductible is used in computing the coinsurance amount for post-hospital extended care services and in computing the monthly part A premium.

House bill

(a) *Inpatient hospital deductible for 1987.*—Sets the inpatient hospital deductible for 1987 at \$500.

(b) *Inpatient hospital deductible for years after 1987.*—No provisions; that is, current law would prevail.

Effective date.—Applies to inpatient hospital services furnished in 1987.

Senate amendment

(a) *Inpatient hospital deductible for 1987.*—Sets the inpatient hospital deductible for 1987 at \$520.

(b) *Inpatient hospital deductible for years after 1987.*—Sets the inpatient hospital deductible for any succeeding year at an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the same percentage that applies to PPS payment rates and adjusted to reflect changes in real case mix. Any amount so determined which is not a multiple of \$4.00 shall be rounded to the nearest \$4.00.

Effective date.—Applies to spells of illness beginning on or after January 1, 1987.

Conference agreement

(a) *Inpatient hospital deductible for 1987.*—The conference agreement includes the Senate amendment with modifications to clarify current law. The part A deductible for calendar year 1987 will be \$520. In subsequent years the part A deductible will be adjusted by the applicable percentage increase (as defined in 1886(b)(3)(B)) for hospital payments under medicare adjusted to reflect changes in real case mix. The part A deductible would continue to be applied on a spell of illness basis.

Current law would be clarified to indicate that the deductible applicable to a hospital stay which falls into two calendar years would be the deductible in effect on the first day of the hospitalization. Applicable cost sharing under part A would continue to be determined based on the annual deductible in effect for the year in which the cost sharing days are incurred. Further, the conference agreement requires that the Secretary of Health and Human Services published within 30 days after enactment the new deductible and coinsurance rates for calendar year 1987.

(b) *Inpatient hospital deductible for year after 1987.*—The conference agreement includes the Senate amendment.

2. APPLICABLE PERCENTAGE INCREASE IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES (SECTION 10202 OF HOUSE BILL; SECTION 601 SENATE AMENDMENT)

Present law

(a-c) *Rate of Increase, Conforming Amendments, and Promulgation of New Rate.*—The Social Security Amendments of 1938 (P.L. 98-21) authorized the Secretary to determine the rate of increase in the payment rates for hospitals included in the prospective payment system (PPS) for FY 1986 and thereafter; taking into account the recommendations of the Prospective Payment Assessment Commission (ProPAC).

HHS issued final rules on September 3, 1985, freezing the PPS payment rates for FY 1986. However, these rules were not implemented because of the enactment of emergency extension legislation which provided that the FY 1986 PPS rates would be frozen at FY 1985 levels through March 14, 1986.

COBRA continued the FY 1986 rate freeze until April 30, 1986, and provided for a rate of increase of $\frac{1}{2}$ of 1 percent for the remainder of the Federal fiscal year for both PPS and PPS-exempt hospitals. In addition, for FY 1987 and FY 1988, it provided that the update factor may not exceed the rate of increase in the market basket index.

The Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177) reduced the FY 1986 Medicare payments to hospitals by 1 percent beginning March 1, 1986.

In proposed rules issued June 3, 1986, HHS provided for an increase of 0.5 percent in the FY 1987 PPS rates and in the target amounts per discharge for PPS-exempt hospitals. In a July 2, 1986, letter to HCFA, ProPAC recommended a 2.2 percent increase in the FY 1987 PPS rates if capital is to be included into the prospec-

tive payment system or a 1.9 percent increase without capital, a rate of increase for PPS-exempt children's hospitals of 3.2 percent, and a rate of increase for other PPS exempt hospitals and units of 3.5 percent.

(d) *FY 1988 update recommendations.*—The Prospective Payment Assessment Commission is required to issue a report to the Secretary on April 1 of each year with its recommendations on ways to update and improve the prospective payment system. The Secretary is required to promulgate proposed PPS regulations not later than June 1 and final PPS regulations not later than September 1.

(e) *PPS-exempt update.*—HHS has argued that a technical change in COBRA prohibits HHS from providing separate update factors for PPS and PPS-exempt hospitals.

(f) *Outlier payments for small rural hospitals and sole community hospitals.*—P.L. 98-21 provided for additional payments to PPS hospitals for "outliers"—cases with very long lengths of stay or extraordinarily high costs compared to most patients classified in the same DRG. The law requires that total outlier payments to all PPS hospitals be not less than 5 percent nor more than 6 percent of the total estimated Medicare prospective payments based on the DRG payment rates for the fiscal year.

COBRA required the Secretary to report to Congress no later than January 1, 1987, on the impact of outlier and patient transfer policies on rural hospitals (particularly on rural hospitals with fewer than 100 beds).

(g) *Computing urban and rural averages.*—P.L. 98-21 provided that PPS hospitals are paid, in part, on the basis of Federal regional and national standardized amounts per discharge. The law requires the calculation of separate urban and rural standardized amounts for each of the nine census regions and for the nation. These standardized amounts represent the urban or rural operating cost per discharge in the base year cost data (1981), averaged across all hospitals in the region (or nation) and updated to the year of payment. In this calculation, the average operating cost per discharge for each hospital is treated the same as the cost per discharge of any other hospital, regardless of how many Medicare discharges the hospital had during the base year. This results in amounts that represent the operating cost per discharge for the average hospital (rather than the average Medicare discharge).

(h) *Regional referral centers.*—PPS hospitals may apply for designation as a regional referral center. In order to qualify, hospitals must meet criteria based on bed size and location, or criteria based on case-mix, admission volume, or patient referrals. Hospitals meeting these criteria are paid prospective payments based on the applicable urban payment rates, rather than the rural rates, and adjusted by the hospital's area wage index.

Under regulations, once a hospital has achieved referral center status, it is paid at the applicable urban rate for a 3-year period.

House bill

(a) *Rate of increase.*—Increases the FY 1987 payment rates for PPS hospitals and PPS-exempt hospitals by 1.0 percent and increases the FY 1988 payment rate by the market basket increase minus 2.0 percent.

(b) *Conforming amendments.*—Provides for conforming amendments.

(c) *Promulgation of new rate.*—Requires the Secretary to republish in the Federal Register the determination of the percent increase which will apply for FY 1987, taking into account the amendments made by this section.

(d) *FY 1988 update recommendations.*—Requires the Secretary to submit a report to Congress by April 1, 1987, providing a documented recommendation on what the Secretary believes the update factor should be for FY 1988.

(e) *PPS-exempt update.*—Provides that PPS-exempt hospitals and units may receive a separate update factor from PPS hospitals.

(f) *Outlier payments for small rural hospitals and sole community hospitals.*—No provision.

(g) *Computing urban and rural averages.*—No provision.

(h) *Regional referral centers.*—Extends the 3-year period granted for regional referral centers status to 4 years. After the 4th year, the hospital would be required to demonstrate, that it continues to meet the criteria. See also item 7(b) (section 10207 of House bill).

Effective date.—Applies rate of increase provision to hospital cost reporting periods beginning on or after October 1, 1986. For the Federal portion of the PPS payment rates, the rate of increase applies to discharges occurring on or after October 1, 1986. Conforming amendments are effective upon enactment. The promulgation of new rates provision requires the Secretary to republish the rate determination in the Federal Register within 30 days after the date of enactment of this Act but in no case later than October 1, 1986, without regard to the provisions of chapter 5 (Administrative Procedures) of title 5 (Government Organization and Employees), United States Code.

Senate amendment

(a) *Rate of increase.*—Increases the FY 1987 payment rates for PPS hospitals and PPS hospitals by 1.3 percent. The marketbasket rate of increase limitation is extended to payment rates for FY 1989.

(b) *Conforming amendments.*—No provision.

(c) *Promulgation of new rate.*—No provision.

(d) *FY 1988 update recommendations.*—No provision.

(e) *PPS-exempt update.*—No provision.

(f) *Outlier payments for small rural hospitals and sole community hospitals.*—Requires the total amount of outlier payments for sole community hospitals with average occupancies of 50 beds or fewer, and small rural hospitals (defined as a hospital in a rural area with fewer than 50 beds) to be not less than 5 percent nor more than 6 percent of the total payments based on DRG prospective payment rates projected or estimated to be made to such hospitals in a given year.

Requires the Prospective Payment Assessment Commission to include in its annual report an analysis of the appropriate thresholds for outliers.

Requires the Secretary to report to Congress no later than January 1, 1987, on the impact of outlier and patient transfer policies on sole community providers.

(g) *Computing urban and rural averages.*—The current formula used to calculate the separate average standardized payment amounts for urban and rural hospitals under PPS would be changed to be based on the number of patients discharged rather than the number of hospitals. This would result in amounts that represent the operating cost per discharge for the average patient as opposed to the average hospital.

(h) *Regional referral centers.*—Hospitals designated as regional referral centers as of the date of enactment shall retain that designation for all hospital cost reporting periods beginning before October 1, 1989.

Provides that to be classified as a regional referral center, a rural hospital must (1) have a case mix equal to or greater than the median case mix for urban hospitals located in the same census region or the Nation (other than hospitals with approved teaching programs); (2) have 5,000 or more discharges a year (or in the case of a rural osteopathic hospital, meets the criterion established by the Secretary for the annual number of discharges); and (3) meet any other criteria established by the Secretary.

Effective date.—Applies rate of increase provision for PPS hospitals to discharges occurring on or after October 1, 1986 (for the Federal portion of the rate), and to discharges occurring in hospital cost reporting periods beginning on or after October 1, 1986 (for the hospital-specific portion of the rate). The rate of increase provision for PPS-exempt hospitals applies to hospital cost reporting periods beginning on or after October 1, 1986. The outlier payments for small rural hospitals and sole community hospitals provision (except the reports required from ProPAC or the Secretary) apply to discharges occurring after September 30, 1986, and before the first October 1 that is more than 270 days after the date on which the Secretary submits the report on outliers required by COBRA. The computing urban and rural averages provision is effective for discharges occurring on or after October 1, 1986. Hospitals which are regional referral centers on the date of enactment shall retain that status for cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989.

Conference agreement

(a) *Rate of increase.*—The conference agreement includes the Senate amendment with modifications. Effective October 1, 1986, the FY 1987 payment rates for PPS hospitals and PPS-exempt hospitals will be increased by 1.15 percent. For FY 1988 the Secretary is required to increase the payment rates for PPS hospitals and PPS-exempt hospitals by an update factor equal to the market basket increase (as defined in Section 1886(b)(3)(B) of the Social Security Act), minus 2 percentage points.

The Secretary of Health and Human Services will be required to adjust the diagnosis-related group (DRG) categories and recalibrate the DRG relative weights annually, beginning in FY 1988, to ensure that the weights reflect the use of new technologies and other practice pattern changes affecting the relative use of hospital resources among DRG categories.

The conference agreement requires that the Secretary publish the June 1 proposed FY 1988 medicare prospective payment regula-

tion—providing for the mandated update factor, adjusting the diagnosis-related group (DRG) categories, recalibrating the DRG relative weights, and making other adjustments as appropriate and within the scope of the law. The final regulation would be published by September 1, 1987, for implementation October 1, 1987.

(b) *Conforming amendments.*—The conference agreement includes the House provision.

(c) *Promulgation of new rate.*—The conference agreement includes the House provision with an amendment requiring promulgation of the new rates no later than 30 days after enactment. Provisions of chapter 5 of title 5 of the U.S. Code would be waived.

(d) *FY 1988 update recommendations.*—The conference agreement includes the House provision with an amendment to require that the Secretary provide a report with recommendations on the projected PPS and PPS-exempt update factors on April 1, 1987 and annually thereafter on March 1. The conference agreement requires that the Secretary, for the FY 1988 update factor provide a report and a documented recommendation to Congress by April 1, 1987, on what the Secretary would recommend for the FY 1988 update factor. Congress will review this report, along with the report of the Prospective Payment Assessment Commission, and make a determination as to what, if any, adjustments should be made to the FY 1988 update factor (established under this legislation at the projected rate of increase in the hospital market basket index minus two percentage points). The Prospective Payment Assessment Commission's annual report submitted to the Secretary as required in Section 1886(e)(4) would be due annually on March 1, effective with the 1988 (FY 1989) annual report. The annual promulgation of the proposed prospective payment regulations currently required to be published no later than June 1 of a year would be moved to no later than May 1, beginning with the 1988 (the FY 1989) update factor. The purpose of requiring submission of the report on March 1 of a year, and promulgation of the proposed regulation on May 1 of a year, is to allow for a sixty day public comment period.

(e) *PPS-exempt update.*—The conference agreement includes the House provision.

(f) *Outlier payments for small rural hospitals and sole community hospitals.*—The conference agreement includes the Senate amendment with a modification. Effective October 1, 1986, a separate urban and separate rural set-aside factor for outliers would be established. The Federal standardized payment amount for each hospital group (i.e., urban hospitals and rural hospitals) would be reduced by the amount necessary to offset the projected outlier payments to that group in the forthcoming fiscal year. For fiscal year 1987 the standardized amount will be reduced by 5 percent to account for outlier payments. The rural standardized payment amounts will be increased by the dollar amount difference between the 5 percent previous reduction and the estimated rural outlier payments for fiscal year 1987 (most recent estimates are that outlier payments to rural hospitals will account for 3 percent of their total payments). The urban standardized amounts will be reduced by an equivalent dollar amount so as to result in the same level of total system payments. The outlier thresholds and standards used

for making additional payments shall be the same as those in effect on October 1, 1986. The conferees expect that the outlier adjustments will continue to be made as the last adjustment to the standardized payment amounts (following the budget neutral restandardization required by section 9104 of P.L. 99-272).

In addition the conference agreement extends for two years the provision of section 1886(d)(5)(C)(ii) of the Social Security Act which provides for an additional payment to sole community hospitals that experience a 5% decrease in volume.

(g) *Computing urban and rural averages.*—The conference agreement includes the Senate amendment with a modification to make the effective date October 1, 1987.

(h) *Regional referral centers.*—The conference agreement includes the Senate amendment with a modification. The Secretary is required to extend the current 3-year period of regional referral center designation for 3 additional years for hospitals so designated on the date of enactment. The provision is further amended to require that in establishing the discharge threshold for eligibility for regional referral center status that the threshold be the lesser of 5,000 discharges or the median number of discharges in urban hospitals in the region in which the hospital is located.

In addition the conference agreement requires the Secretary to conduct a secondary rural referral center demonstration at Lake Region Hospital and Nursing Home in Fergus Falls, Minnesota.

3. LIMITATION ON PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES OF DRG HOSPITAL UNDER MEDICARE (SECTION 10203 OF HOUSE BILL; SECTION 602 OF SENATE AMENDMENT)

Present law

The Social Security Amendments of 1983 (P.L. 98-21) established a prospective payment system (PPS) for making payments on a per discharge basis to hospitals for the operating costs of inpatient services provided to Medicare beneficiaries. Hospital capital-related costs for inpatient services (including depreciation, leases and rentals, interest, and a return on equity for proprietary hospitals) are excluded from the definition of operating cost for PPS and are reimbursed on a reasonable cost basis. This exclusion from the operating costs was to expire on October 1, 1986, but was extended until October 1, 1987, by the Urgent Supplemental Appropriations Act (P.L. 99-349).

Current law provides that if Congress did not enact legislation by October 1, 1987, to include capital-related costs under PPS, Medicare payment for capital costs would be prohibited unless a State has a capital expenditure review agreement with the Secretary (under section 1122 of the Social Security Act) and the State has recommended approval of the specific capital expenditure.

House bill

(a) *Payment limitation.*—Requires the Secretary to cap the aggregate amount of PPS hospital capital-related payments. The cap for FY 1987 shall be the aggregate amount of hospital capital payments in 1986 as estimated by the Secretary plus 10 percent; for FY 1988 will be limited to the aggregate amount of hospital capital

payments in FY 1986 plus 20 percent; and for FY 1989 will be limited to the aggregate amount of hospital capital payments in FY 1986 plus 30 percent. The FY 1986 base and the allowable costs reimbursed will be adjusted to reflect the phasing-out of payments for return on equity capital.

The Secretary would be permitted to adjust the FY 1986 base in each of the following fiscal years based on the most recent available data.

(b) Publication of capital reduction percentage.—If the Secretary determines the target limits will be exceeded, the Secretary would be required to determine and publish the appropriate capital reduction percentage for each fiscal year required to maintain payments within the limit. The percent would be based upon the best available information before the beginning of the fiscal year involved.

Requires the Secretary to publish in the Federal Register, no later than 30 days after the date of the enactment of this Act or, if earlier, by October 1, 1986, the capital reduction percentage for FY 1987. In promulgating the percentage for FY 1987, the provisions of chapter 5 (Administrative Procedures) of title 5 (Government Organization and Employees), United States Code, and of chapter 35 (Programs for Older Americans) of title 41 (Public Contracts), United States Code, shall not apply.

(c) No administrative or judicial review.—Prohibits administrative or judicial review of the capital reduction percentage.

(d) Interim and final payments.—Interim and final payments would be based on the percentage determined by the Secretary for portions of cost reporting periods occurring during the fiscal year.

(e) Sole community hospitals.—No provision.

Effective date.—Applies to payments for capital-related costs attributable to portions of cost reporting periods occurring on or after October 1, 1986.

Senate amendment

(a) Payment limitation.—Requires the Secretary to reduce the amounts for capital-related payments to PPS hospitals otherwise determined to be reasonable under current law, by 3 percent for cost reporting period beginning on or after October 1, 1986, and before October 1, 1987; by 5 percent for cost reporting periods beginning on or after October 1, 1987, and before October 1, 1988; and by 6 percent for cost reporting periods beginning on or after October 1, 1988, and before October 1, 1989.

(b) Publication of capital reduction percentage.—No provision.

(c) No administrative or judicial review.—No provision.

(d) Interim and final payments.—No provision.

(e) Sole community hospitals.—Does not apply to the capital-related costs of sole community hospitals.

Effective date.—Cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989.

Conference agreement

(a) Payment limitation.—The conference agreement includes the Senate amendment with modifications. The Secretary is required to reduce the amounts for capital-related payments to PPS hospitals otherwise determined to be reasonable under current law, by 3.5

percent for portions of cost-reporting periods occurring in FY 1987; by 7 percent for FY 1988; and by 10 percent for FY 1989. The conferees expect that all capital costs (including return on equity payments and funded depreciation offsets) will be included in the base for calculating the payment reductions. The conferees anticipate that the reductions will be implemented on a pro rata monthly basis.

It is the intent of the conferees that the Congress reconsider the issue of payment for capital-related costs to hospitals under medicare in the forthcoming year. The conferees anticipate that, during this period, the Congress will develop a legislative proposal to incorporate capital payments under medicare into the prospective payment system. The conferees intend that this proposal will continue cost-related reimbursement for capital-related financial obligations, or enforceable agreements entered into, in the past by hospitals. The Conferees expressly indicate that at this time there be no specific date as to when a capital-related cost would be considered "obligated" for purposes of a "grandfather" clause.

If the Congress does not exercise its prerogative to legislate on this matter, the conference agreement recognizes that the Secretary has the authority, beginning in FY 1988, to incorporate capital-related costs into the prospective payment system. In promulgating any regulations which would incorporate capital payments into the prospective payment system, the Secretary shall ensure that the medicare total aggregate payments for capital under the new prospective payment system shall be neither more nor less than the payments that would otherwise have been provided under this section (i.e. be "budget neutral"). The Secretary is prohibited, between September 1, 1986 and September 1, 1987, from promulgating final regulations that change the methodology for computing the amount of payment for capital-related costs under title XVIII of the Social Security Act.

Further, the conference agreement provides a technical amendment to clarify that if the Secretary chooses not to incorporate capital into the prospective payment system, cost reimbursement would continue for capital-related costs, subject to the limitations in the conference agreement.

(b) *Publication of capital reduction percentage.*—The conference agreement does not include the House provision.

(c) *Administrative or judicial review.*—The conference agreement does not include the House provision.

(d) *Interim and final payments.*—The conference agreement does not include the House provision.

(e) *Sole community hospitals.*—The conference agreement includes the Senate amendment exempting, for three years, sole community providers from capital-related payment reductions and further would exempt, for three years, sole-community providers from a prospective payment system for capital if provided by the Secretary under regulations.

4. COVERAGE OF HOSPITALS IN PUERTO RICO UNDER DRG PROSPECTIVE PAYMENT SYSTEM (SECTION 10204 OF HOUSE BILL)

Present law

Hospitals outside the 50 States and the District of Columbia are excluded by law from the prospective payment system (PPS) and are paid on the basis of reasonable costs, subject to the TEFRA rate of increase limits.

The Secretary is required to report on methods of making payments to hospitals in the territories, including Puerto Rico, under a prospective payment system by April 1, 1984. The report has not yet been submitted.

House bill

(a) *In general.*—Requires the Secretary to include eligible Puerto Rico hospitals in PPS. A hospital would be included in PPS if it is located in Puerto Rico and otherwise would be a PPS hospital if it were located in one of the 50 States.

(b) *Payment rate.*—Establishes payment amounts based on the sum of: (1) 75 percent of the Puerto Rico adjusted standardized payment amount; and (2) 25 percent of the national adjusted standardized payment amount.

(c) *Base used to establish Puerto Rico amount.*—Requires the Secretary to determine each hospital's target amount per discharge (under section 223) for hospital cost reporting periods beginning in FY 1986.

(d) *Updating the base.*—Requires the Secretary to increase the hospital's target amount per discharge by the applicable percentage increase for FY 1987.

(e) *Standardizing the amount.*—Requires the Secretary to standardize this amount by: (1) excluding an estimate of indirect medical education costs; (2) adjusting for variations in the Puerto Rico average hospital wage level; and (3) adjusting for variations in case mix among hospitals.

(f) *Urban and rural hospitals.*—Requires the Secretary to calculate an average standardized amount for urban and for rural hospitals.

(g) *Additional reductions.*—Requires the Secretary to reduce the Puerto Rico standardized amounts by a proportion equal to the proportion (estimated by the Secretary) that outlier payments and disproportionate share payments represent of total Puerto Rico payments.

(h) *Puerto Rico prospective payment rate.*—Requires the Secretary to establish Puerto Rico urban and rural prospective payment rates for discharges within a DRG, equal to the urban or rural average standardized amount, with the additional reductions, multiplied by the weighting factor for that diagnosis related group.

(i) *Area wage adjustment.*—Requires the Secretary to adjust the proportion (as estimated by the Secretary from time to time) of hospital costs attributable to wages and wage-related costs for area differences in hospitals wage levels by a factor (established by the Secretary) reflecting the relative wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level.

(j) *FY 1988 and beyond.*—Requires the Secretary, for each hospital discharge after FY 1987, to compute the Puerto Rico adjusted DRG prospective payment rate by: (1) using the hospital's respective urban or rural average standardized amount as computed (in (f) above) for the previous fiscal year; (2) increasing this amount by the applicable percentage increase; and (3) by carrying out the steps described in (e) through (i) above.

(k) *National adjusted standardized payment amount.*—Requires the Secretary to determine the average of the national adjusted standardized payment amounts for urban and for rural hospitals.

(l) *Additional payments.*—Provides for payment to Puerto Rico PPS hospitals in the same manner and to the same extent as they apply to other PPS hospitals for the following: outlier payments (except that the total amount of outlier payments to Puerto Rico hospitals may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made for Puerto Rico hospitals for discharges in that year), payments for indirect medical education costs (except that the calculation would conform to Puerto Rico's payment methodology), exceptions and adjustments, payments for costs of certified registered nurse anesthetists, and disproportionate share payments (except that the calculation would conform to Puerto Rico's payment methodology).

(m) *Conforming amendments.*—Provides for conforming amendments.

(n) *No restandardization of national levels to reflect inclusion of Puerto Rico.*—Prohibits the Secretary from restandardizing or otherwise adjusting the national DRG prospective payment rates to take into account Puerto Rico's inclusion into the prospective payment system.

Effective date.—Applies to cost reporting periods beginning on or after October 1, 1986. The Secretary is required to issue regulations no later than October 1, 1986, to implement such amendments without regard to the provisions of chapter 5 (Administrative Procedures) of title 5 (Government Organization and Employees), United States Code.

Senate amendment

No provision.

Conference agreement

(a) *In general.*—The conference agreement includes the House provision with a modification to include eligible Puerto Rico hospitals into the medicare prospective payment system effective for discharges occurring on or after October 1, 1987.

(b) *Payment rate.*—The conference agreement includes the House provision with technical corrections.

(c) *Base used to establish Puerto Rico amount.*—The conference agreement includes the House provision with a modification moving the effective date to October 1, 1987.

(d) *Updating the base.*—The conference agreement includes the House provision with a modification to move the effective date forward by one year and to make other technical amendments.

(e) *Standardizing the amount.*—The conference agreement includes the House provision with technical amendments.

(f) *Urban and rural hospitals.*—The conference agreement includes the House provision with a modification to require urban and rural standardized amounts to be discharge weighted (as opposed to hospital weighted).

(g) *Additional reductions.*—The conference agreement includes the House provision with technical clarifications.

(h) *Puerto Rico prospective payment rate.*—The conference agreement includes the House provision with technical clarifications.

(i) *Area wage adjustment.*—The conference agreement includes the House provision with technical amendments.

(j) *FY 1988 and beyond.*—The conference agreement includes the House provision.

(k) *National adjusted standardized payment amount.*—The conference agreement includes the House provision with a modification to require urban and rural standardized amounts to be discharge weighted (as opposed to hospital weighted).

(l) *Additional payments.*—The conference agreement includes the House provision with a modification to reduce the Federal standardized payment amount for Puerto Rico (i.e., separately for urban hospitals and for rural hospitals) by the amount necessary to offset the projected outlier payments to each subgroup of hospitals in Puerto Rico in the forthcoming fiscal year.

(m) *Conforming amendments.*—The conference agreement includes the House provision.

(n) *No restandardization of national levels to reflect inclusion of Puerto Rico.*—The conference agreement includes the House provision with a modification to require that the Secretary reduce the national and regional standardized payment amounts by the proportion necessary to assure that aggregate payments to PPS hospitals (including hospitals in Puerto Rico) in FY 1988 are neither greater nor less than the aggregate payments that would have been made to such hospitals under prior law (i.e., this section must be “budget neutral”).

5. IMPROVING QUALITY OF CARE WITH RESPECT TO PART A SERVICES (SECTION 10205 OF HOUSE BILL; SECTIONS 604 AND 614 OF SENATE AMENDMENT)

Present law

(a) *Refinement of Prospective Payment System.*—Under Medicare’s prospective payment system (PPS) hospitals are paid a predetermined rate based on a patient’s diagnosis-related group (DRG) classification. The patient is classified into one of 468 DRGs based on his or her primary diagnosis, secondary diagnosis, primary procedure, age, and discharge status. Payment rates for each DRG reflect the average cost of providing care to patients classified in the DRG.

(b) *Requiring Notice of Hospital Discharge Rights.*—On February 24, 1986, the Secretary instructed hospitals to provide Medicare inpatients with a notice explaining hospital discharge procedures under PPS and patients’ rights to appeal discharge decisions. There is no statutory requirement that a statement of patient rights be distributed.

(c) *Requiring Hospitals to Provide Discharge Planning Process.*—By regulation, hospitals participating in Medicare must have a discharge planning program to facilitate the provision of follow-up care.

(d) *Review of Standards for Medicare Conditions of Participation for Assuring Quality of Inpatient Hospital Services.*—For a hospital to be eligible for Medicare reimbursement, the hospital must be in compliance with Medicare's conditions of participation for hospitals as set forth in subchapter B of title 42 of the Code of Federal Regulations or must be accredited by a national accreditation body, such as the Joint Commission on Accreditation of Hospitals.

(e) *Study of Payment for Administratively Necessary Days.*—Under Medicare's prospective payment system (PPS) hospitals are paid a predetermined rate based on a patient's diagnosis-related group (DRG) classification. The patient is classified into one of 468 DRGs based on his or her primary diagnosis, secondary diagnosis, primary procedure, age, and discharge status. Payment rates for each DRG reflect the average cost of providing care to patients classified in the DRG. No special provision is made for separate payment for "administratively necessary days." An administratively necessary day is a day of continued inpatient hospital stay necessitated by delays in obtaining placement of a patient in a skilled nursing facility.

(f) *Continuing Waiver of Liability or SNFs, Home Health Agencies, and Hospice Programs.*—Under waiver of liability, payment may be made for services which are not covered because they were not reasonable and necessary or were for custodial care if neither the beneficiary nor the provider knew or could reasonably have been expected to know that the services were not covered for these reasons. By regulation, a home health agency is presumed to meet this test if its denial rate on claims for services is 2.5 percent or less. A SNF is presumed to meet the test if its denial rate is 5.0 percent or less. Hospice providers are not eligible for a favorable presumption.

Final regulations published February 21, 1986, eliminated the favorable presumption of the waiver of liability. Payment for noncovered services would have continued on a case-by-case basis. However, COBRA maintained the favorable presumption criteria for SNFs and home health agencies. As a result of the law, the favorable presumption will be continued until October 7, 1988, for SNF services. The favorable presumption for home health services will be continued until 12 months after claims processing for home health agencies has been consolidated under 10 regional intermediaries.

(g) *Extension of Waiver of Liability Provisions to Certain Coverage Denials for Home Health Services.*—Beneficiaries who are homebound and require skilled nursing services on an intermittent basis or physical, occupational, or speech therapy are eligible for home health services. Program guidelines provide fiscal intermediaries and home health agencies with information and guidance about coverage determinations for patients who are "homebound" or whether skilled nursing and home health aide services are "intermittent." The current waiver of liability protection does not apply to noncovered home health services if the reason for the

denial is because the patient was determined not to be confined to his home or not to need skilled nursing care on other than an intermittent basis. Denials of these kinds are often referred to as technical denials.

(h) Development of Uniform Needs Assessment Instrument.—There is no comparable requirement in current law.

(i) Expedited Review by Fiscal Intermediaries.—Claims for skilled nursing facility, home health services, and hospice care services generally are reviewed on a retrospective basis after the services are provided. Standards for timeliness in claims submission and review are not provided in present law.

(j) Including in Annual Reports on Prospective Payment System Information on Quality of Post-Hospital Care.—The Secretary is required to report on the impact of the prospective payment methodology for inpatient hospital services, due annually at the end of each year for 1984 through 1987.

(k) Prior Authorization Demonstration Project.—Medicare fiscal intermediaries have responsibility for deciding whether payment will be made for services provided by home health agencies and SNFs. Generally, these payment decisions are made on a retrospective basis after services are provided.

House bill

(a) Refinement of prospective payment system.—

(1) Development of legislative proposal.—Requires the Secretary to submit to Congress a specific legislative proposal to improve the classification and payment system under PPS (including the system for payment of outliers) in order to assure that the amount of payment per discharge approximates the cost of medically necessary care provided in an efficient manner for individual patients or classes of patients with similar conditions.

(2) Accounting for severity of illness.—Requires the Secretary, in developing the proposal, to account for variations in severity of illness and case complexity which are not adequately accounted for by the current classification and payment system.

(3) Deadline.—Requires the proposal be submitted to Congress by no later than 2 years after the date of enactment.

Effective date.—Enactment.

(b) Requiring notice of hospital discharge rights.—Requires hospitals to provide to each beneficiary (or to a legally responsible person acting on the beneficiary's behalf), at or about the time of the beneficiary's admission as an inpatient, a written statement which explains (1) the beneficiary's rights to Medicare benefits for inpatient hospital services and for post-hospital services, (2) the circumstances under which the beneficiary will and will not be liable for charges for a continued hospital stay, (3) the beneficiary's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and (4) the beneficiary's liability for payment for services if such a denial of benefits is upheld on appeal, and which provides any additional information as the Secretary may specify.

Effective date.—Requires the Secretary to first prescribe the language no later than 6 months after the date of enactment. Applies

to admissions to hospitals occurring on such date as the Secretary shall provide, but no later than 60 days after the date such language is first prescribed.

(c) *Requiring hospitals to provide discharge planning process.*—

(1) *Requirement as a condition of participation.*—Requires hospitals as a condition of participation for Medicare to have a discharge planning process.

(2) *Discharge planning process defined.*—Considers a discharge planning process sufficient if it is applicable to services furnished by the hospital to Medicare beneficiaries and if it meets the guidelines and standards established by the Secretary.

Requires the Secretary to develop these guidelines and standards in order to ensure a timely and smooth transition to the most appropriate type of setting for post-hospital or rehabilitative care. These guidelines and standards must include the following: (a) the hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning; (b) the hospital must provide a discharge planning evaluation for the identified patients and for other patients upon the request of the patient, patient's representative, or patient's physician; (c) any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge; (d) a discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services and the availability of those services; (e) the discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative); (f) upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient; (g) any such discharge planning evaluation or discharge plan must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel.

(3) *Effect on accreditation.*—Provides that the requirement of discharge planning may not be satisfied by accreditation of the hospital accreditation body action pursuant to section 1865 of the Social Security Act unless the Secretary determines that the discharge planning standards of the accreditation body are at least equivalent to the standards required under this provision.

Effective date.—Applies as of one year after the date of enactment.

(d) *Review of standards for medicare conditions of participation for assuring quality of inpatient hospital services.*—Requires the Secretary to arrange for a study of the adequacy of the standards used for hospitals, for the purposes of meeting Medicare's conditions of participation in assuring the quality of services furnished in hospitals. Requires the Secretary to report to Congress on the results of the study by no later than 2 years after the date of enactment.

Effective date.—Enactment.

(e) *Study of payment for administratively necessary days.*—

(1) *In general.*—Requires the Secretary to conduct a study to determine whether a payment should be made (in a budget-neutral way for PPS hospitals) to a hospital for administratively necessary days, separate from the DRG and outlier payments.

(2) *Administratively necessary days defined.*—Defines an “administratively necessary day” as a day of continued inpatient hospital stay, for a part A beneficiary, necessitated by a delay in obtaining placement for the individual in a skilled nursing facility.

(3) *Consideration in conducting study.*—Requires the Secretary, in conducting the study, to consider the need for such a payment to minimize the disproportionate financial impact of current law on certain hospitals (or hospitals in certain locations) due to difficulties in arranging for appropriate post-hospital care such as difficulties resulting from a shortage of beds in skilled nursing facilities where those hospitals are located and difficulties resulting from the source of payment for such care.

Requires the Secretary, in conducting the study, to consider the need for a payment to minimize the risk of inappropriate discharge to a non-institutional or inappropriate institutional setting of individuals who need post-hospital services in a skilled nursing facility.

Requires the Secretary, in conducting the study, to consider the administrative mechanisms that can be used to prevent inappropriate payments for administratively necessary days.

(4) *Report on study.*—Requires the Secretary to report to Congress on the results of the study no later than January 1, 1988.

Effective date.—Enactment.

(f) *Continuing waiver of liability for SNFs, home health agencies, and hospice programs.*—Continues the favorable presumption of waiver of liability for SNFs and home health agencies, and establishes a favorable presumption for hospices having 2.5 percent or fewer claims denied on the basis of care not being reasonable and necessary or determined to be custodial in nature.

Requires the Secretary to report annually to Congress on (1) the frequency and distribution of denials because care was not reasonable and necessary or was custodial; and (2) other information needed to evaluate the appropriateness of denial rates established for a favorable presumption.

Effective date.—For hospices, effective for care furnished on or after the first day of the first month that begins at least 6 months after date of enactment and before October 1, 1989. For SNFs and home health agencies, effective for services furnished on or after date of enactment and before October 1, 1989.

(g) *Extension of waiver of liability provisions to certain coverage denials for home health services.*—Extends waiver of liability for home health agencies to coverage decisions about whether a patient is homebound or whether a person needs skilled nursing care on an intermittent basis or physical, speech, or occupational therapy. A favorable presumption regarding the waiver of liability for

denials on these ground would be available for home health agencies which (1) comply with requirements on timely submittal of bills for payment and medical documentation, (2) promptly notify patients where it is determined that a patient is being or will be furnished items or services which are excluded from coverage, and (3) have no more than 2.5 percent of claims submitted during the previous quarter denied on the basis of home bound or intermittent care requirements.

Effective date.—Effective for services furnished on or after the first day of the first month that begins more than 90 days after date of enactment, with the favorable presumption provisions for denials based on homebound and intermittent coverage decisions effective through September 30, 1989.

(h) Development of uniform needs assessment instrument.—

(1) Development.—Requires the Secretary to develop a uniform need assessment instrument that (A) evaluates the functional capacity of an individual, the nursing and other care requirements of the individual to meet health care needs and to assist with functional incapacities, and the social and familial resources available to the individual to meet those requirements; and (B) can be used by discharge planners, hospitals, nursing facilities, other health care providers, and fiscal intermediaries in evaluating an individual's need for post-hospital extended care services, home health services, and long-term care services of a health related or supportive nature. The Secretary may develop more than one such instrument for use in different situations.

(2) Advisory panel.—Requires the Secretary to develop the instrument in consultation with an advisory panel appointed by the Secretary. The panel is to include experts in the delivery of post-hospital extended care services, home health services, and long-term care services, and is to include representatives of hospitals, physicians, skilled nursing facilities, home health agencies, long-term care providers, fiscal intermediaries, and Medicare beneficiaries.

(3) Report of instrument.—Requires the Secretary to report to Congress, no later than 1 year after the date of enactment, on the instrument or instruments developed. The report is required to include an evaluation of the advantages to include an evaluation of the advantages and disadvantages of using the instrument or instruments as the basis for determining whether payment should be made for post-hospital extended care services and home health services provided to Medicare beneficiaries.

Effective date.—Enactment.

(i) Expedited review by fiscal intermediaries.—Requires the Secretary to develop procedures to expedite the determination of whether initial claims submitted for skilled nursing facility, home health services, and hospice care services provided (or to be provided) to an individual may be reimbursed by Medicare, in order to minimize the time between when the provider first provides the service to the individual and when the provider first receives notice of an initial determination on whether Medicare will pay for some or all of the provided services.

Effective date.—Requires the Secretary to provide for the expedited procedures no later than one year after the date of enactment.

(j) *Including in annual reports on prospective payment system information on quality of post-hospital care.*—

(1) *Additional reports.*—Extends the requirement for annual reports through 1989.

(2) *Information on Quality of post-hospital care.*—Requires the annual impact reports to include (A) an evaluation of the adequacy of the procedures for assuring quality of Medicare post-hospital services; (B) and assessment of problems that have prevented groups of Medicare beneficiaries (including those eligible for Medicaid) for receiving appropriate Medicare post-hospital services; and (C) information on Medicare reconsiderations and appeals for payment for post-hospital services.

Effective date.—Enactment. Applies to reports for years beginning with 1986.

(k) *Prior authorization demonstration project.*—Requires the Secretary of HHS to conduct a demonstration program concerning prior authorization for Medicare SNF and home health services. Requires the demonstration to include at least four projects implemented not later than July 1, 1987. Requires the Secretary to waive compliance with Medicare requirements to the extent and for the period the Secretary finds necessary to conduct the demonstration.

Requires that the demonstration be developed in consultation with an advisory panel that includes experts in the delivery of SNF services home health services, and long-term care services and include representatives of hospitals, physicians, SNFs, home health agencies, long-term care providers, fiscal intermediaries, and Medicare beneficiaries.

Requires the Secretary to evaluate the demonstration and report to Congress on the evaluation no later than January 1, 1989. Requires the Secretary to address the following issues in the evaluation: (1) the administration in comparison to costs under the current system of retroactive review, including costs for uncovered services paid under the waiver of liability which would not be incurred under prior authorization; (2) impact of prior authorization on access and availability of SNF and home health services in comparison to the current system and on timely discharge of hospital inpatients; and (3) accuracy and associated cost savings of payment determinations and rates of claim reversals under prior authorization versus the current system.

Specifies that funding for the demonstration would come from the Federal Hospital Insurance Trust Fund.

Effective date.—Enactment.

Senate amendment

(a) *Refinement of prospective payment system.*—No provision.

(b) *Requiring notice of hospital discharge rights.*—Section 604(a).—Similar provision.

Effective date.—Requires the Secretary to first prescribe the language no later than 6 months after the date of enactment. Applies to admissions to hospitals occurring after such date as the Secre-

tary shall provide, no later than 60 days after the date such language is first prescribed.

(c) *Requiring hospitals to provide discharge planning process.*—Section 604(b).

(1) *Requirement as a condition of participation.*—Identical provision.

(2) *Discharge planning process defined.*—Similar provision.

(3) *Effect on accreditation.*—Similar provision.

Effective date.—Applies as of one year after the date of enactment.

(d) *Review of standards for Medicare conditions of participation for assuming quality of inpatient hospital services.*—No provision.

(e) *Study of payment for administratively necessary days.*—No provision.

(f) *Continuing waiver for liability for SNFs, home health agencies, and hospice programs.*—No provision.

(g) *Extension of waiver of liability provisions to certain coverage denials for home health services.*—Section 614.—Extends waiver of liability protection for home health agencies to coverage decisions about whether a patient is homebound or whether a person needs skilled nursing care on an intermittent basis.

Requires the Secretary not later than July 1, 1987, to publish final regulations specifying criteria used as of Jan. 1, 1986, in determining coverage for patients who are homebound or who require skilled nursing care on an intermittent basis.

Effective date.—Effective for coverage denials occurring on or after July 1, 1987.

(h) *Development of uniform need assessment instrument.*—No provision.

(i) *Expedited review of fiscal intermediaries.*—No provision.

(j) *Including in annual reports on prospective payment system information on quality of post-hospital care.*—No provision.

(k) *Prior authorization demonstration project.*—Section 604(c).—Requires the Secretary to develop and carry out a demonstration project to determine whether prior and concurrent authorization for SNF and home health services, when used in place of the current waiver of liability policy, will protect beneficiaries against liabilities incurred as a result of claim denials. Requires the Secretary to monitor claim denials. Requires the Secretary to monitor the acceptance of beneficiaries by providers to ensure that their placement is not delayed until the results of prior and concurrent review are known. Requires that the demonstration be initiated not later than January 1, 1987, and continue for not more than 2 years.

Authorizes the Secretary to require providers participating in the demonstration to submit such information as the Secretary determines is necessary to evaluate the project. Requires the Secretary to report to Congress on the result of the evaluation not later than April 2, 1988.

Effective date.—Enactment.

Conference agreement

(a) *Refinement of prospective payment system.*—The conference agreement includes the House provision.

(b) Requiring notice of hospital discharge rights.—The conference agreement includes the House provision.

(c) Requiring hospitals to provide discharge planning process.—The conference agreement includes the House provision with the following clarification. Standards for discharge planning should be applied in a flexible manner in the case of small rural hospitals.

(d) Review of standards for medicare conditions of participation for assuring quality of inpatient hospital services.—The conference agreement includes the House provision.

(e) Study of payment for administratively necessary days.—The conference agreement includes the House provision.

(f) Continuing waiver of liability for SNFs, home health agencies, and hospice programs.—The conference agreement includes the House provision with respect to the application of the favorable presumption of liability rules to hospice providers through November 1, 1988. The conference agreement does not include the House provision that would extend the favorable presumption of the waiver of liability for home health agencies and SNFs through FY 1989.

Because many of the denials for payment to home health agencies by fiscal intermediaries stem from the lack of a clear and consistent implementation of the requirements that a patient be “homebound” and in need of “intermittent” skilled care, the conferees urge the Secretary to promulgate clearer definitions of these terms and provide better guidance to agencies and fiscal intermediaries.

(g) Extension of waiver of liability provision to certain coverage denials for home health services.—The conference agreement includes the House provision with amendments. The waiver of liability for “technical” denials would not include denials based on possible need for physical, speech, or occupational therapy. The effective date is delayed to July 1, 1987. The Secretary would be required to report on the frequency of denials for SNF, home health agency, and hospice benefits.

The Secretary would be required to report on the frequency and distribution of payment denials for extended care services, home health services and hospice care in 1987 and 1988.

(h) Development of uniform needs assessment instrument.—The conference agreement includes the House provision. The conferees note that an evaluation of the functional status of an individual should include not only a description of the individual's diagnosis, but an evaluation of the constraints on the individual's ability to engage in activities of daily living.

(i) Expedited review by fiscal intermediaries.—The conference agreement does not include the House provision.

(j) Including in annual reports on prospective payment system information on quality of post-hospital care.—The conference agreement includes the House provision.

(k) Prior authorization demonstration project.—The conference agreement includes the House provision with technical amendments. The agreement further changes the date for implementation of the demonstration from July 1, 1987 to January 1, 1987 and delays the date for submission of a report to Congress from January 1, 1989 to February 1, 1989.

6. OFF-BUDGET TREATMENT OF FEDERAL HOSPITAL INSURANCE TRUST
FUND IN FISCAL YEAR 1987 (SECTION 10206 OF HOUSE BILL)

Present law

Federal Hospital Insurance (HI) Trust Fund receipts and disbursements are included in the unified budget of the U.S. Government, but are scheduled to be removed from the unified budget in FY 1993.

The Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177) removed the receipts and disbursements of the Social Security Trust Funds (the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, known as OASDI) from the unified budget effective for FY 1986. The disbursements and expenditures of the Social Security Trust Funds, however, are included for purposes of determining whether the deficit exceeds the "maximum deficit amount" targets set in the Gramm-Rudman-Hollings legislation.

House bill

Removes the receipts and disbursements of the Federal Hospital Insurance (HI) Trust Fund, from the unified budget of the U.S. Government. As under OASDI, the disbursements and expenditures of the HI trust fund would be included for purposes of determining whether the deficit exceeds the "maximum deficit amount" targets set in the Gramm-Rudman-Hollings legislation and would be exempt from any general budget limitation on outlays imposed by statute.

Effective date.—Applies to fiscal years beginning after September 30, 1986, and end before October 1, 1992.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

7. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS
RELATING TO PART A (SECTION 10207 OF HOUSE BILL)

Present law

(a) *One-year extension of pass-through for costs of certified registered nurse anesthetists.*—See item (section 4524 of House bill) for this description.

(b) *Extended designation period for regional referral centers.*—See item 2 (section 10202 of House bill; section 601 of Senate amendment) for this description.

(c) *Temporary waiver of inpatient limitations for the Connecticut Hospice, Inc.*—Medicare-certified hospices are required to maintain no more than 20 percent of total days as inpatient days. Connecticut Hospice, Inc., currently has waivers for a number of Medicare requirements. These waivers will no longer be in effect on October 1, 1986.

(d) *Massachusetts Medicare repayment.*—Massachusetts operated a Statewide hospital demonstration project from October 1, 1982,

through June 30, 1986. The Secretary is required to judge the effectiveness of the demonstration to ensure that Medicare expenditures under the demonstration are not greater than they would have been under Medicare regular reimbursement rules. The Secretary has determined that Medicare part A overpayments were made during the first two years of the Massachusetts waiver and has established a repayment schedule for the alleged overpayments.

(3) *Part A COBRA technical and other miscellaneous corrections.*—Current law contains a number of technical errors.

House bill

(a) *One-year extension of pass-through for costs of certified registered nurse anesthetists.*—See item 18 (section 4524 of House bill) for this description.

(b) *Extended designation period for regional referral centers.*—See item 2(h) (Section 10202 of House bill; section 601 of Senate amendment) for this description.

(c) *Temporary waiver of inpatient limitations for the Connecticut Hospice, Inc.*—Waives Connecticut Hospice, Inc., from the 80/20 inpatient/home care day requirement for two years, provided they do not exceed 50 percent of total days as inpatient days.

(d) *Massachusetts Medicare repayment.*—Prohibits the Secretary from recouping or otherwise reducing payments to Massachusetts hospitals on or after the date of enactment of this section and before January 1, 1988.

(e) *Part A COBRA technical and other miscellaneous corrections.*—Corrects technical errors as follows: (1) corrects and clarifies a section regarding payments under the disproportionate share provision; (2) corrects and clarifies a section regarding payments under the indirect teaching adjustment; (3) clarifies that all hospitals which have a Medicare provider agreement would have to abide by the emergency care requirements; (4) allows SNFs to make election to be paid on a prospective payment basis based on their cost reporting periods rather than on a Federal fiscal year basis; (5) clarifies that the Hospital Insurance tax on State and local government does not apply to certain election workers (Note: see Revenue Provisions, item 1 (section 661 of Senate amendment) for a description of a similar provision.); and (6) makes other miscellaneous corrections to COBRA and related laws.

Effective date.—Enactment, except the technical corrections are effective as if they had been included in the enactment of the laws they amend.

Senate amendment

(a) *One-year extension of pass-through for costs of certified registered nurse anesthetists.*—No provision.

(b) *Extended designation period for regional referral centers.*—See item 2 (Section 10202 of House bill; Section 601 of Senate amendment) for this description.

(c) *Temporary waiver of inpatient limitations for the Connecticut Hospice, Inc.*—No provision.

(d) *Massachusetts Medicare repayment.*—No provision.

(e) *Part A COBRA technical and other miscellaneous corrections.*—No provision. Note: See Revenue provisions, item 1 (Section

661 of Senate amendment) for a description of a similar provision regarding election worker exemption from Hospital Insurance tax.

Conference agreement

(a) *One-year extension of pass-through for costs of certified registered nurse anesthetists.*—The conference agreement includes the House provision (see item 19(a)).

(b) *Extended designation period for regional referral centers.*—The conference agreement includes the Senate amendment (see item 2(h)).

(c) *Temporary waiver of inpatient limitations for the Connecticut Hospice, Inc.*—The conference agreement includes the House provision.

(d) *Massachusetts Medicare repayment.*—The conference agreement includes the House provision.

(e) *Part A COBRA technical and other miscellaneous corrections.*—The conference agreement does not include the House provision except with regard to a hospital accounting year amendment.

8. MEDICARE PAYMENTS TO LARGE RURAL HOSPITALS SERVING A DISPROPORTIONATE SHARE OF LOW-INCOME PATIENTS (SECTION OF SENATE AMENDMENT)

Present law

COBRA provided that additional payments will be made—for discharges occurring on or after May 1, 1986 but before October 1, 1988—to PPS hospitals that serve a disproportionate share of low-income patients.

For urban PPS hospitals with 100 or more beds having a percentage of low-income patients of at least .15 percent, the Federal portion of the PPS payment is increased by 2.5 percent plus half the difference between 15 percent and the hospital's percentage of low-income patients, not to exceed 15 percent. For urban hospitals with less than 100 beds having a percentage of low-income patients of at least 40 percent, the Federal portion of the PPS payment is increased by 5 percent.

For rural hospitals having a percentage of low-income patients of at least 45 percent, the Federal portion of the PPS payment is increased by 4 percent.

The percentage of low-income patients is defined as the hospital's total number of medicare-covered inpatient days attributable to Medicare patients who are eligible for Federal Supplemental Security Income benefits, divided by the total number of Medicare-covered patient days, plus the number of Medicaid-covered patient days divided by the hospital's total patient days.

Payments are also made to urban hospitals with 100 or more beds which demonstrate that more than 30 percent of their inpatient revenues are derived from State and local government payments for indigent care (excluding payments under Medicare and Medicaid).

House bill

No provision.

Senate amendment

Allows the Secretary to establish a separate threshold percentage of low-income patients required for rural hospitals with 300 or more beds to qualify for Medicare disproportionate share payments. These hospitals would have the Federal portion of the PPS payment increased by the same formula currently used for urban hospitals with 100 or more beds (2.5 percent plus half the difference between 15 percent and the hospital's percentage of low-income patients, not to exceed 15 percent).

Rural hospitals with less than 300 beds would continue to be required to have a percentage of low-income patients of at least 45 percent in order to qualify for Medicare disproportionate share payments. These hospitals would continue to have their payment increased by 4 percent.

Effective date.—Applies to discharges occurring on or after October 1, 1986.

Conference agreement

The conference agreement includes the Senate amendment with an amendment to change the bed threshold to 500. In addition, the present law provision which allows payments to disproportionate share hospitals will be continued for one additional year in a budget neutral fashion.

II. MEDICARE PROVISIONS (PARTS A AND B)

9. ELIMINATION OF PERIODIC INTERIM PAYMENTS (PIP) FOR PROSPECTIVE PAYMENT SYSTEM (PPS) HOSPITALS AND PROMPT PAYMENT FOR MEDICARE PROVIDERS (SECTION 10221 OF HOUSE BILL; SECTION 612 OF SENATE AMENDMENT)

Present law

Current law does not specifically provide for periodic interim payments (PIP); however, regulations allow hospitals, skilled nursing facilities, and home health agencies which meet certain requirements to receive Medicare periodic interim payments (PIP) every 2 weeks, based on estimated annual costs without regard to the submission of individual bills. At the end of the year, a settlement is made. In final regulations published on August 15, 1986, the Department of Health and Human Services eliminated PIP for most PPS and PPS-exempt hospitals, effective July 1, 1987.

The Health Care Financing Administration recently issued guidelines requiring each part A intermediary and part B carrier to process at least 95 percent of "clean" Medicare claims within 27 days of receipt. "Clean" Medicare claims are those not requiring development for payment safeguard activities or additional information. The guidelines apply to Medicare claims submitted by beneficiaries, physicians, providers, and suppliers.

House bill

(a) *Elimination of PIP for PPS hospitals.*—Eliminates periodic interim payments for inpatient services in PPS hospitals (including distinct psychiatric or rehabilitation units of PPS hospitals) except for disproportionate share hospitals, sole community hospitals, and

hospitals receiving Medicare payment under a State hospital reimbursement system if payment on a PIP basis is an integral part of the reimbursement system.

Eligible PPS-exempt hospitals and other costbased providers (i.e., outpatient hospitals skilled nursing facilities, and home health agencies) may continue to receive periodic interim payments.

If a PPS hospital has significant cash flow problems resulting from operations of its intermediary or from unusual circumstances of the hospital's operation, the Secretary is required to make available accelerated payments.

(b) Part A prompt payment.—Provides (for Medicare claims not paid on a PIP basis) that if payment is not made by a part A intermediary by the 22nd calendar day after the day on which a clean claim is received, interest would accrue beginning on the day after the day on which payment was due and ending on the day payment is made. Intermediaries are required to notify the beneficiary or provider who submits a claim, within 22 calendar days after the date on which a claim is received, of any defect, impropriety, or circumstance that prevents the claim from being treated as a clean claim. If such notice is not provided on a timely basis and the claim is eventually paid, interest would accrue beginning on the day after the day the notice is required and ending on the day payment is made or the day notice is provided, whichever is earlier.

(c) Part B prompt payment.—Provides (for Medicare claims not paid on the PIP basis) that if payment is not made by a part B carrier by the 22nd calendar day (or by the 11th calendar day in the case of a participating physician or supplier) after the date on which a clean claim is received, interest would accrue beginning on the day after the day on which payment was due and ending on the day payment is made. Part B carriers are required to notify the beneficiary, physician, or supplier who submits a claim, within 22 calendar days (or by the 11th calendar day in the case of a participating physician or supplier) after the date on which a claim is received of any defect, impropriety, or circumstance that prevents the claim from being treated as a clean claim. If such notice is not provided on a timely basis and the claim is eventually paid, interest would accrue beginning on the day after the date the notice is required and ending on the day payment is made or the day notice is provided, whichever is earlier.

(d) Interest Rate.—Interest under this provision is paid at the rate used for purposes of section 3902(a) (Interest Penalties) of title 31 (Money and Finance), United States Code.

(e) Federal administrative costs.—Carriers and intermediaries will be reimbursed for interest payments from amounts made available for Federal administrative costs to carry out this provision (other than the amounts made available for intermediary and carrier agreements).

(f) Definition of "clean" claim.—A "clean" claim is defined as a claim that has no defect or impropriety (including missing required substantiating documentation) or particular circumstances requiring special treatment that prevents timely payment.

(g) Timely amendments to agreements and regulations.—No provision.

Effective date.—Applies PIP provision for discharges occurring on or after August 1, 1987. The timely payment for part A claims provision applies to claims received on or after October 1, 1987. The prompt payment for Medicare physicians and suppliers provision applies to claims received on or after October 1, 1987.

Senate amendment

(a) Elimination of PIP for PPS hospitals.—Eliminates periodic interim payments for inpatient services in PPS hospitals (including distinct psychiatric or rehabilitation units of PPS hospitals).

The elimination of PIP for PPS hospitals would be delayed until the intermediary demonstrates that it has complied with the prompt payment requirement for at least three consecutive months. If the intermediary fails to meet the prompt payment requirements for three consecutive months, all the PPS hospitals it serves may choose to be placed on PIP.

Eligible PPS-exempt hospitals and other cost-based providers (i.e., skilled nursing facilities and home health agencies) may continue to receive periodic interim payments.

(b) Part A prompt payment.—Requires (for Medicare claims not paid on a PIP basis) payment to be made by a part A intermediary for at least 95 percent of all Medicare clean claims by the applicable number of calendar days after the day on which a clean claim is received. In FY 1987, the applicable number of calendar days is 27, FY 1988 it is 26, in FY 1989 it is 25, and in FY 1990 and thereafter, it is 24.

For clean claims not paid on a PIP basis, if payment is not made by the applicable number of days after the date on which a clean claim is received, interest would be paid beginning on the day after the date on which payment was due, and ending on the date payment is made.

(c) Part B prompt payment.—Provides (for Medicare claims not paid on a PIP basis) that if payment is not made by a part B carrier for at least 95 percent of all Medicare clean claims by the applicable number of calendar days after the day on which a clean claim is received, interest would be paid beginning on the day after the day on which payment was due and ending on the day payment is made.

(d) Interest rate.—Similar provision.

(e) Federal administrative costs.—No provision.

(f) Definition of "clean" claim.—A "clean" claim is defined as a claim which meets Medicare requirements for payment under part A or part B respectively. In addition, in order for a part A claim to be a clean claim it must meet the requirements of section 1814(a)(1) (which defines a Medicare claim).

(g) Timely amendments to agreements and regulations.—Requires the Secretary to provide for timely amendments to intermediary and carrier agreements and regulations to the extent necessary to implement these provisions.

Effective date.—Applies to claims received on or after October 1, 1986, except that the interest penalties apply to claims received on or after April 1, 1987.

Conference agreement

(a) *Elimination of PIP for PPS hospitals.*—The conference agreement includes the Senate amendment with a modification. Under the agreement, the elimination of periodic interim payment (PIP) would not apply to prospective payment system hospitals (and their distinct psychiatric or rehabilitation units) with a disproportionate share adjustment percentage of at least 5.1 percent. For purposes of this provision, the disproportionate share adjustment shall be based upon the data base used for establishing the standardized amounts for fiscal year 1987 (i.e., the disproportionate share percentage calculated from the hospital's percentage of low income patients, which were based on the SSI percentage from 1985 SSI data and the medicaid percentage from 1984 cost report data). Prospective payment system hospitals with 100 or fewer beds located in rural areas could also qualify for continued periodic interim payments.

On a one-time basis during the cost reporting period beginning in fiscal year 1987, qualified disproportionate share and qualified rural hospitals could elect to continue receiving periodic interim payments provided that they were receiving such payments on June 30, 1987 and provided that they continue to meet the requirements specified in regulations that were applicable on October 1, 1986. Qualification for periodic interim payments for eligible disproportionate share hospitals and eligible rural hospitals with 100 beds or less would be limited to those hospitals which qualify under this exception during the cost reporting period beginning in fiscal year 1987. These qualified hospitals could continue to receive PIP payments indefinitely provided that they continue to meet standards established by the Secretary that were applicable on October 1, 1986. The conferees expect the Health Care Financing Administration to identify hospitals which would qualify for continued PIP payments and to inform such hospitals of their one-time opportunity to continue PIP payments.

The conferees recognize that elimination of PIP may present serious financial difficulties for certain hospitals. In addition to the current criteria under which accelerated payments are generally available, accelerated payments to hospitals should be made available by the Secretary if the hospital can demonstrate that it is experiencing significant cash flow difficulties resulting from operations of the intermediary or from unusual circumstances of the hospital's operation.

The PIP option would be retained for PPS-exempt hospitals, skilled nursing facilities, home health agencies, and hospitals in states holding waivers under section 1886(c) or section 1814(b)(3); and would be made available to hospice providers. The conferees require that the payment mechanism and requirements be comparable to those which are currently in place under 42 CFR 405.454(j).

(b) *Part A prompt payment.*—The conference agreement includes the Senate amendment with a modification which specifies that 95 percent of "clean" claims shall be paid in not more than 30 calendar days in FY 1987; 26 for FY 1988; 25 for FY 89 and 24 for FY 1990 and for each of the subsequent years.

Periodic interim payments could not be eliminated for hospitals receiving such payments until the intermediary has met the prompt payment standards for three consecutive months. Periodic interim payments could be provided for those hospitals that meet the standards required by the Secretary, as in place as of October 1, 1987, if an intermediary fails to meet the applicable prompt payment standard for three consecutive months. For providers not receiving periodic interim payments interest would be required to be paid on claims not processed within the specified time periods.

(c) *Part B prompt payment.*—The conference agreement includes the Senate amendment with a modification which specifies that 95 percent of “clean” claims shall be paid in not more than 30 calendar days in FY 1987; 26 for FY 1988; 25 for FY 1989; and 24 for FY 1990 and for each of the subsequent years except that for participating physicians the standard shall be 19 days for FY 1988; 18 for FY 1989 and 17 for FY 1990 and for each subsequent years. For claims not paid within the specified time period interest would accrue.

The conferees are concerned about the rapid slow down in payments to beneficiaries and providers that has developed over the last year. The conferees hope that intermediaries and carriers process claims in the most expeditious manner and consider the limits established in this bill as an absolute ceiling with a goal of processing claims according to historical experience. The conferees urge the Administration to manage more appropriately the payment function carried out by medicare’s intermediaries and carriers and that the Administration request funds necessary to improve the administration of the medicare program and to pay claims in a timely manner consistent with the historical levels.

The Secretary should establish standards for timely payment of claims that do not meet the definition of “clean” claims or fail to meet the 95 percent minimum requirement. The conferees do not expect that the exclusion of some claims from timeliness requirements in this bill will result in increased numbers of claims classified as incomplete.

(d) *Interest rate.*—The conference agreement includes the House provision.

(e) *Federal administrative costs.*—The conference agreement includes the House provision.

(f) *Definition of clean claims.*—The conference agreement includes the Senate amendment with an amendment clarifying the definition of a clean claim. A “clean” claim is defined as a claim that has no defect or impropriety (including the absence of required substantiating documentation) or particular circumstances requiring special treatment that prevents timely payment.

(g) *Timely amendments to agreements and regulations.*—The conference agreement includes the Senate amendment.

10. HEALTH MAINTENANCE ORGANIZATION AMENDMENTS (SECTIONS 10222 AND 4510 OF HOUSE BILL)

Present law

Section 1876 of the Social Security Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), provides for

Medicare payments to Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) on either a risk or a cost contracting basis. In general, risk contracting plans are financially responsible for the cost of all benefits their enrollees would otherwise be eligible for under Medicare while enrolled in these plans.

(a) *Two for one rule.*—Section 114(c)(2) of TEFRA provides the HMOs with enrolled individuals under an existing cost-contract and convert such individuals to enrollment under a risk contract. However, the plan must enroll two new Medicare enrollees under the risk contract for each enrollee converted from the cost to the risk contract. This provision is known as the “two for one” rule.

(b) *Explanation of enrollee rights.*—Each HMO and CMP must meet certain requirements to be eligible to contract with the Secretary to enroll Medicare members. These requirements include accepting financial responsibility for contracted services and providing for meaningful grievance procedures. The enrolling member of a risk contracting plan accepts that, except for emergency and out-of-area care, neither the plan nor Medicare has financial responsibility for services not rendered by or through the contracting plan.

(c) *Restriction on waivers of 50 percent Medicare and Medicaid enrollment.*—Each Medicare contracting HMO and CMP must have at least half of their membership composed of enrollees that are not entitled to benefits under either Medicare or Medicaid. The Secretary can waive this requirement only if circumstances warrant such waiver and the organization is making reasonable efforts to enroll individuals not entitled to Medicare or Medicaid.

(d) *Prompt payment of claims.*—Each HMO and CMP is financially responsible for the cost of benefits used by its enrollees, whether provided directly or under arrangement.

(e) *Financial disclosure.*—Each HMO and CMP is required to comply with Section 1318 of the Public Health Service Act (relating to financial disclosure).

(f) *Civil monetary penalties.*—Medicare contracts with HMOs and CMOs are automatically annually renewable, unless the Secretary determines that the organization has failed to meet its contractual obligations. The Secretary may terminate such contracts at any time if it is found (after appropriate notice and opportunity for hearing) that the organization has substantially failed to carry out the terms of the contractual requirements.

(g) *Study of AAPCC and ACR.*—Reimbursement of risk contracting HMOs and CMPs is determined based on estimates of the average adjusted per capita cost (AAPCC) and the adjusted community rate (ACR).

(h) *Allowing Medicare beneficiaries to disenroll at a local Social Security office.*—No provision.

House bill

(a) *Two for One rule.*—

Section 10222.—Amends TEFRA such that the “two for one rule” does not apply for current nonrisk HMO Medicare enrollees for months beginning with April 1987.

Section 4510.—No provision.

(b) *Explanation of enrollee rights.*—

Section 10222.—Requires HMOs and CMPs contracting on either a risk or cost basis to provide each enrollee at the time of enrollment, and not less than annually thereafter, an explanation of the enrollee's rights, including enrollee's rights to benefits from the organization, restrictions on Medicare payments for services provided other than by or through the organization, out-of-area coverage, coverage of emergency services, and appeal rights of enrollees.

Section 4510.—No provision.

(c) *Restriction on waivers of 50 percent Medicare and Medicaid enrollment.*—

Section 10222.—

(1) Limits the Secretary's authority to issue new waivers of the 50 percent rule to plans with service areas that include populations more than half of which are entitled to either Medicare or Medicaid.

(2) Provides that, if an eligible organization fails to comply with the requirements for a waiver, the Secretary may suspend enrollment of Medicare enrollees by the organization.

(3) Provides that, in the case of organizations that currently have a waiver but that do not meet the requirements for such waiver as amended by this section, the Secretary is given the authority to suspend enrollments under Medicare if the organization does not meet scheduled enrollment goals approved by the Secretary.

Section 4510.—

(1) Similar provision.

(2) Provides that, if an eligible organization fails to comply with the requirements for a waiver, the Secretary may provide for a suspension of Medicare payments to the organization.

(3) Provides that, in the case of organizations that currently have a waiver but that do not meet the requirements for such waiver as amended by this section, the Secretary is given the authority to suspend payments under Medicare.

(d) *Prompt payments of claims.*—

Section 10222.—Requires that risk contracting organizations must provide for payment of claims submitted for covered services and supplies furnished to their enrollees by physicians, providers and suppliers not having a contractual arrangement with the organization within the same time limits for prompt payment that apply to Medicare carriers and fiscal intermediaries. If, after notice and opportunity for a hearing, an organization fails to make prompt payments, the Secretary may provide for direct payment of amount owed and then deduct the amount of such payments (and amounts incurred by the Secretary in making such payments) from payment otherwise made to such organizations.

Section 4510.—No provision.

(e) *Financial disclosure.*—

Section 10222.—Requires that HMOs and CMPs supply, on request of the Secretary and according to regulations specified

by the Secretary, information as to ownership of subcontractors with whom the organization had business transactions in excess of \$25,000 during the preceding 12 months, and complete information regarding significant business transactions between organizations and wholly owned subcontractors or suppliers during the 5-year period preceding the date of such request. The organization is required to notify the Secretary of loans or other special financial arrangements between the organization and its subcontractors, affiliates, and related parties.

Section 4510.—No provision.

(f) Civil money penalties.—

Section 10222.—Provides that any risk-contracting organization that fails substantially to provide any medically necessary items and services that are required to be provided under such contract, is subject to a civil money penalty of not more than \$2,000 for each such failure if the failure has adversely affected (or has the likelihood of adversely affecting) individuals enrolled under such contract. Such penalties are subject to the requirements generally applicable to civil money penalties under Section 1128A of the Social Security Act (except for subsection (a)).

Section 4510.—No provision.

(g) Study of AAPCC and ACR.—

Section 10222.—Requires the Secretary to provide, through a contract with an appropriate organization, for a study of the methods by which the AAPCC and the ACR can be refined to more accurately reflect the cost of providing care to different classes of patients, and to submit to Congress not later than January 1, 1988 specific legislative recommendations concerning the methods by which these measures can be refined.

(h) Allowing Medicare Beneficiaries to Disenroll at a Local Social Security Office.—

Section 10222.—Requires the Secretary to provide that beneficiaries may disenroll from HMOs and CMPs at any local office of the Social Security Administration on or after June 1, 1987.

Section 4510.—No provision.

Effective date.—*Section 10222.*—Enactment except for the following:

(b) January 1, 1987.

(c) Except for subsection (3) relating to current waivers, applies to modifications and waivers granted after enactment.

(d) Applies to services furnished on or after July 1, 1987.

(e) Applies to contracts as of January 1, 1987.

Section 4510.—Except for subsection (3) relating to current waivers, applies to modifications and waivers granted after enactment.

Senate amendment

No provision.

Conference agreement

(a) Two for One rule.—The conference agreement includes section 10222 of the House provision.

(b) *Explanation of enrollee rights.*—The conference agreement includes section 10222 of the House provision. All HMO/CMP's would be required to provide medicare beneficiaries an explanation of their rights as HMO enrollees, including but not limited to understandable descriptions of the benefits package, the meaning of any "lock-in" provisions, the scope of out-of-area coverage and emergency and urgently needed services and appeal rights. This information would be supplied to beneficiaries enrolled in risk contract HMO/CMP's effective January 1, 1987 and no less often than every January thereafter.

Restriction of waivers of 50 percent Medicare and Medicaid enrollment.—The conference agreement includes section 10222 of the House provision with two amendments:

(1) *Restrictions on new waivers*—New waivers may only be granted "to the extent that" more than 50 percent of the population area served by the organization consists of individuals who are entitled to benefits under this title or under a State plan approved under title XIX.

New waivers of the requirements of section 1876(f)(1) of the Act would be allowed, at the discretion of the Secretary, for a period not to exceed three years if the organization is publicly owned and operated. The conferees note that the original purpose of this requirement was to ensure that the organization remain financially sound, and that it be of sufficient quality to attract nonmedicare enrollees. Because the financial viability of a publicly owned HMO would be guaranteed by the government, but such an HMO would typically serve a disproportionate share of medicaid and medicare beneficiaries, the requirements of section 1876(f)(1) do not serve their purpose and can appropriately be waived.

(2) *Sanctions for noncompliance*—If an eligible organization fails to comply with the requirements for a waiver, the Secretary may suspend medicare payments to the organization for beneficiaries newly enrolled after the date of a finding of noncompliance, and may also suspend new reenrollment of medicare beneficiaries by the organization.

In the case of organizations that currently have a waiver but that do not meet the requirements for such waiver as amended by this section, the Secretary would be given the authority to suspend medicare payments for beneficiaries newly enrolled after the date of a finding of noncompliance, and to suspend new enrollments if the organization does not meet scheduled enrollment goals approved by the Secretary.

No new waivers of the current rule requiring that no more than 50 percent of enrollees be medicare or medicaid eligible would be granted other than for exceptions specified in the bill. Where an existing waiver has been granted for reasons other than "disproportionate" representation, the Secretary must establish a schedule under which each waived organization can meet the 50/50 requirement. Where a waiver has been granted for other than "disproportionate" representation, the waivers may only be extended if the Secretary determines that the organization (or its successor) has made and is continuing to make reasonable efforts to meet scheduled enrollment goals

approved by the Secretary. The Secretary would be given authority to suspend further medicare enrollment if the waived HMO/CMP fails to meet its enrollment schedule (in order to come into compliance with the 50/50 rule). If the HMO/CMP does not have a 50/50 waiver, but is out of compliance with the 50/50 rule, the Secretary would be given authority to freeze new medicare enrollment and to suspend medicare payments for new enrollments after the finding of non-compliance.

The conference agreement clarifies that the Secretary has the authority, to terminate (after reasonable notice and opportunity for hearing) contracts entered into under section 1876 if the organization substantially fails to meet the requirements of the new section 1876(f) relating to the 50/50 membership requirements.

(d) *Prompt payment of claims.*—The Conference agreement includes section 10222 of the House provision with an amendment that the requirements of the provision become effective with respect to services furnished on or after January 1, 1987. Effective beginning on January 1, 1987 until December 31, 1987, “clean” claims submitted for services and supplies furnished to HMO/CMP enrollees pursuant to a Section 1876 contract furnished by physicians, providers and suppliers not having a contractual arrangement with the organization must be paid within thirty calendar days of receipt by the HMO/CMP. The conferees encourage HMO/CMP’s to pay such claims in a shorter period than the maximum of 30 calendar days as required in this bill, especially in light of the fact that HMO/CMP’s are paid prospectively by the medicare program. For calendar year 1988 the prompt payment standard would be 26 days; for 1989, 25 days; and for 1990 and beyond, 24 days. If the standards are not met, the Secretary would have the authority to provide for direct payment of the amounts owed to such providers and suppliers. In this case, the Secretary would provide for an appropriate reduction in the amount of payments otherwise made to the organization to reflect such payments.

(e) *Financial disclosure.*—The conference agreement includes section 10222 of the House provision.

(f) *Civil monetary penalties.*—The conference agreement includes section 10222 of the House provision with an amendment that the amount of the penalty is equal to \$10,000 for each substantial failure to provide medically necessary items or services that are required to be provided under the contract. In determining whether the requirements of this section were breached, the Secretary is expected to take into consideration generally accepted HMO practice patterns for the delivery of medically necessary care.

(g) *Study of the AAPCC and ACR.*—The conference agreement includes section 10222 of the House provision.

(h) *Allowing Medicare beneficiaries to disenroll at a local Social Security office.*—The conference agreement includes section 10222 of the House provision.

(i) *Use of benefit stabilization funds during the 1986 contract year.*—The conference agreement allows amounts withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund under section 1876(g)(5) during the 1986 contract period to be withdrawn by

the organization to the extent that the organization was paid less than it would have otherwise been paid under a risk contract with the Secretary as a result of Federal spending reductions triggered under the Balanced Budget and Emergency Deficit Control Act of 1985.

11. PROVISIONS RELATING TO IMPROVEMENT OF QUALITY OF CARE (SECTION 10223 OF HOUSE BILL; SECTIONS 614 AND 615 OF SENATE AMENDMENT)

Present law

(a) *Provider representation of beneficiaries on appeals and appeal of technical denials.*—If a beneficiary disagrees with a payment denial for services provided under Medicare Part A, he or she is entitled to appeal the determination. In the past, beneficiaries have been permitted to be represented in their appeals by the provider who furnished the services in question. However, in April 1984, HCFA issued an intermediary manual instruction prohibiting such representation. HCFA also has prohibited appeals of “technical” denials, such as homebound and intermittent care requirements for home health services.

(b) *Prohibition of certain physician incentive plans.*—Section 1866(d) of the Social Security Act provides for Medicare payments to most hospitals on a prospective basis. These PPS hospitals are responsible for the costs of all medically necessary part A inpatient services provided to Medicare beneficiaries during their inpatient stay. Section 1876 of the Social Security Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), provides for Medicare payments to Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) on either a risk or a cost contracting basis. In general, risk contracting plans are financially responsible for the cost of all benefits their enrollees would otherwise be eligible for under Medicare while enrolled in these plans.

(c) *Study to develop a strategy for quality review and assurance.*—No provision.

House bill

(a) *Provider representation of beneficiaries on appeals and appeal of technical denials.*—Allows providers to represent beneficiaries on appeals, but prohibits representation by a provider with respect to issues described in section 1879(a)(2) of the Social Security Act unless the provider has waived any rights for payment from the beneficiary for services involved in the appeal.

Provides beneficiaries the right to appeal any payment denial for benefits under part A or part B home health services.

Effective date.—Enactment.

(b) *Prohibition of certain physician incentive plans.*—

(1) *Prohibition of incentive payments.*—Prohibits a hospital or risk-contracting HMO or CMP from knowingly making incentive payments to a physician as an inducement to reduce or limit services provided to Medicare beneficiaries who are under the direct care of the physician. With respect to HMOs and CMPs, the prohibition applies to Medicare enrollees of

such entities. Hospitals and risk-contracting HMOs and CMPs who knowingly make such payments are subject to civil money penalties of \$2,000 for each such individual with respect to whom the payments are made, in addition to any other penalties that may be prescribed by law. Any physician who knowingly accepts such incentive payments is subject to a civil money penalty of \$2,000 for each such individual with respect to whom such payments are made, in addition to any other penalties prescribed by law.

(2) *Study of incentive arrangements.*—Requires the Secretary to conduct a study of incentive arrangements offered to physicians by HMOs and CMPs, and to report the findings to Congress no later than April 1, 1987. The report shall include recommendations for providing exceptions for such organizations from the prohibition specified under (1) for incentive payments that encourage efficiency in the utilization of services but do not have a substantial potential for an adverse effect on quality.

Effective date.—The prohibition and civil money penalty provisions apply to payments made by hospitals occurring more than 6 months after enactment, and to payments made by risk contracting plans on or after January 1, 1988.

(c) *Study to develop a strategy for quality review and assurance.*—

(1) *In general.*—Requires the Secretary to arrange for a study to serve as the basis for establishing a strategy for reviewing and assuring the quality of care under medicare.

(2) *Items included in the study.*—The study is required among other items, to (a) identify the appropriate considerations which should be used in defining "quality of care"; (b) evaluate the relative roles of structure, process, and outcome standards in assuring quality of care; (c) consider whether criteria and standards for defining and measuring quality of care should be developed and, if so, how this should be done; (d) evaluate the adequacy and focus of the current methods for measuring, reviewing, and assuring quality of care; (e) evaluate the current research on methodologies for measuring quality of care, and suggest areas of research needed for further progress; (f) evaluate the adequacy and range of methods available to correct or prevent identified problems with quality of care; (g) review mechanisms available for coordinating and supervising at the national level quality review and assurance activities; and (h) develop general criteria which may be used in establishing priorities in the allocation of funds and personnel in reviewing and assuring quality of care.

(3) *Report.*—Requires the Secretary to report to Congress, no later than 2 years after the date of enactment. The report shall address the items in (2) above and shall include recommendations with respect to strengthening quality assurance and review activities for Medicare services.

(4) *Arrangement for study.*—Requires the Secretary to request the National Academy of Sciences, acting through appropriate units, to submit an application to conduct the study described in this subsection. If the Academy submits an acceptable application, the Secretary is required to enter into an ap-

propriate arrangement with the Academy for conducting the study. If the Academy does not submit an acceptable application, the Secretary may request one or more appropriate non-profit private entities to submit an application to conduct the study and may enter into an arrangement for the study with the entity which submits the best application.

Requires the Secretary, in developing plans for the conduct of the study, to assure that consumer and provider groups, peer review organizations, the Joint Commission on Accreditation of Hospitals, professional societies, and private purchasers of care with experience and expertise in the monitoring and quality of care are consulted.

Effective date.—Enactment.

Senate amendment

(a) *Provider representation of beneficiaries on appeals and appeal of technical denials.*—Similar provision, except prohibits provider representing beneficiary from imposing any financial liability on the beneficiary in connection with representation. Also prohibits costs incurred by provider for representing a beneficiary in an unsuccessful appeal from being allowed as reasonable costs.

Provides beneficiaries the right to appeal payment denials for home health services that do not meet the “intermittent or home bound” criteria.

Effective date.—For provider representation provisions, effective on enactment. For technical denials provisions, effective for coverage denials occurring on or after July 1, 1987.

(b) *Prohibition of certain physician incentive plans.*—No provision.

(c) *Study to develop a strategy for quality review and assurance.*—No provision.

Conference agreement

(a) *Provider representation of beneficiaries on appeals and appeals of technical denials.*—The conference agreement includes the Senate amendment.

(b) *Prohibition of certain physician incentive plans.*—The conference agreement includes the House provision with an amendment extending its applications to Medicaid. The agreement modifies the House requirement for HMOs and CMPs by extending the period of exemption to April 1, 1989. The Secretary would be required to conduct a study of the impact of physician incentive arrangements and make legislative recommendations to refine the prohibition as it relates to HMOs and CMPs by January 1, 1988. The provision does not apply to incentive plans approved by the Secretary as part of a demonstration project.

(c) *Study to develop a strategy for quality review and assurance.*—The conference agreement includes the House provision with an amendment concerning coordination of quality of care studies. The Secretary of Health and Human Services (HHS) would be required to designate an office with responsibility for coordinating the planning of studies on quality of care, including the development of priorities for quality studies. The office would also be responsible for coordinating access to data necessary to conduct the studies and for

maintaining a clearinghouse on PPS quality studies conducted by HHS and other entities. Such office may be located within the Health Care Financing Administration.

12. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PARTS A AND B (SECTIONS 10224, 4504, AND 4509 OF HOUSE BILL)

Present law

(a) *Treatment of group purchasing vendor agreements.*—It is prohibited to receive, give, solicit, or offer any remuneration in return for referring or arranging for the furnishing of any item or service or in return for purchasing, leasing, or ordering any good, facility, or service for which payment can be made under Medicare.

Some hospitals and other providers purchase medical supplies and equipment through their participation in group purchasing organizations (GPOs). GPOs purchase goods and services for participating institutions. A service or transactional fee is charged to participating institutions by GPOs. In some situations, fees are also paid by the vendor or supplier in order to participate in the GPO agreement. This practice constitutes a technical violation of Medicare anti-fraud and abuse preventions.

(b) *Extension and clarification of competitive contracting authority.*—DEFRA provided the Secretary with the authority to enter into two competitively bid contracts under part A and two such contracts under part B to replace poor performing contractors, i.e., intermediaries and carriers. This authority expires on September 30, 1986.

While the Secretary has used this authority to enter into competitively bid cost contracts, competitive bidding has not been used in the negotiation of fixed-price contracts.

(c) *Parts A and B COBRA technical corrections.*—Current law contains a number of technical errors.

(d) *Delay in promulgation of regulations.*—The Secretary may at any time issue regulations, instructions to Medicare carriers and fiscal intermediaries, and other instruments which change Medicare policy. Regulations must be issued in final form prior to August 15 or prior to October 6 to be included in the August or October Gramm-Rudman-Hollings baseline. As an exception to this general rule, proposed regulations updating prospective payments for hospital operating costs are included in the August or October Gramm-Rudman-Hollings baseline if they are issued prior to the August 15 or October 6 deadline.

House bill

(a) *Treatment of group purchasing vendor agreements.*—

Section 10224.—Permits the payment of administrative fees to group purchasing organizations by a vendor if the purchasing agent has an appropriate written contract and full disclosure of the payment is made to each provider.

Section 4594.—Similar provision.

Section 4509.—No provision.

(b) *Extension and clarification of competitive contracting authority.*—

Section 10224.—Extends the authority of the Secretary for 3 years to enter into competitively bid contracts with intermediaries and contractors to replace poor performing contracts. Language would be clarified to include fixed-price contracting.

Section 4504.—No Provision.

Section 4509.—No Provision.

(c) Parts A and B COBRA technical corrections.—

Section 10224.—Corrects technical errors as follows: (1) clarifies that a 1-year transition period is provided for foreign medical graduates (FMGs) who have not passed the Foreign Medical Graduate Examination in the Medical Sciences from July 1, 1986, through June 30, 1987, such a FMG will be counted at a rate equal to one-half of the rate at which the individual would otherwise be counted; (2) allows the Secretary to announce rather than publish health maintenance organization and competitive medical plan rates by September 7 of each year; (3) clarifies effective date of the provision regarding penalties for billing for assistants at surgery for certain cataract operations; (4) allows temporary use of carrier prepayment screening as a substitute for preprocedure review; (5) clarifies that the termination date of the ACCESS demonstration project is July 31, 1987; and (6) makes other miscellaneous corrections to COBRA and related laws.

Section 4504.—No provision.

Section 4509.—Identical provision.

(d) Delay in promulgation of regulations.—The Secretary would be prohibited from issuing in final form any regulation, instruction, or other policy before September 15, 1987, which is estimated by the Secretary to achieve Medicare savings in fiscal year 1987 of more than \$50,000,000, except as required to implement specific provisions required under statute. The Secretary would also be prohibited from publishing in final form any regulation regarding changes in the methodology for computing the amount of payment for capital-related costs for inpatient hospital services under Medicare part A between September 1, 1986 and September 1, 1987. References in current law to regulations issued in final or proposed form pursuant to Sections 1886(b)(3)(B), 1886(d)(3)(A), and 1886(e)(4) of the Social Security Act would be clarified. Under this provision, no such reference would be construed as including any regulation issued or proposed with respect to capital-related costs.

Effective date.—(a) Applies to payments made before, on, or after the date of enactment; (b) applies to contracts entered into on or after October 1, 1986; (c) applies as if it had been included in the enactment of COBRA; and (d) enactment.

Senate amendment

No provision.

Conference agreement

(a) Group purchasing agreements.—The conference agreement includes the House provision with an amendment. The conference agreement follows section 4504 of the bill which would exclude amounts paid by vendors of goods and services to authorized purchasing agents for groups of hospitals, nursing homes or other enti-

ties and individuals furnishing medicare services. The conference agreement would delete the reference to a specific percentage limit on the amount of such a fee. The deletion was made because of a concern that specifying a percentage might establish a norm for all such fees, resulting in increases in current fees that are typically below the amount specified. The Secretary shall monitor these arrangements for possible abuse, particularly those in excess of 3 percent. In addition, the conference agreement would require disclosure of fees paid by medicare providers as prescribed by the Secretary in regulations.

(b) *Competitive contracting*.—The conference agreement includes the House provision with an amendment which would clarify the Secretary's authority to enter into competitively bid fixed price contracts.

(c) *COBRA technicals*.—The conference agreement does not include the House provision.

(d) *Moratorium on HCFA regulations*.—The conference agreement includes the House provision with an amendment to prohibit the Secretary from issuing any regulation, instruction or other policy regarding hospitals or physicians before September 1, 1987 which would achieve medicare savings of more than \$50 million in fiscal year 1988.

The conference agreement also prohibits the Secretary from issuing final regulations that change the methodology for computing the amount of payment for capital-related costs for inpatient hospital services under part A before September 1, 1987.

The agreement also requires that the Secretary allow 60 days for public comment on proposed regulations and notices, except for limited circumstances when such comment periods are not possible due to statutorily imposed deadlines for Secretarial action. This provision does not require the Secretary to provide an opportunity for public comment for items (such as interpretive rules, general statements of policy, or rules of agency organization, procedure or practice) that are not currently subject to that requirement. (See also item #2 and #3).

13. DIRECT COSTS OF GRADUATE MEDICAL EDUCATION (SECTION 4501 OF HOUSE BILL)

Present law

COBRA restructure the manner in which Medicare reimburses teaching hospitals for the direct cost they incur for graduate medical education. Effective with cost reporting periods beginning on or after July 2, 1985, hospitals are to receive payment on the basis of a formula that takes into account each hospital's previous average cost per full-time equivalent resident, the number for full-time equivalent residents during the period for which reimbursement is being made, and the hospital's proportion of total inpatient days used by Medicare patients during that period.

(a) *Clarifying counting of time spent in out patient settings*. Time spent by residents out of the inpatient setting is counted for this purposes only if the setting is part of the hospital.

(b) *Reducing maximum initial residence period*.—Beginning on July 1, 1986, distinctions are made among residents, for purposes of

counting their full-time equivalency in this formula, and different weighting factors are applied depending on how many years of resident training they have completed. Residents are weighted at 1.00 during the period needed to obtain their first board eligibility, plus one additional year, not to exceed a total of 5 years. This results in full payments for either 4 or 5 years. After the initial residency period, payments are reduced; beginning on July 1, 1987, payments for such residents are reduced to half (i.e., a weight factor of .50) of what they would otherwise have been.

House bill

(a) *Clarifying counting of time spent in outpatient settings.*—Counts only time spent in patient care activities towards the determination of full-time equivalency (used in determining of payments for direct graduate medical education costs), and counts all time so spend by a resident under an approved medical residency training program, without regard to the setting in which the activities are performed, if the hospital incurs costs for the training program in that setting.

(b) *Reducing Maximum Initial residency period.* Reduces the length of the initial residency period from 5 years to 4 years. As a result, the support for the fifth year of residency is reduced by half (i.e., a weighting factor of .50), conforming to policy adopted in COBRA for the sixth and succeeding years.

Provides a one year transition, from July 1, 1987, through June 30, 1988, during which support for the fifth year of residency is reduced by one-quarter (i.e., a weighting factor of .75 instead of .50) for a resident whose support would otherwise be reduced by half.

Effective date.—Applies to payments for approved residency training programs as of July 1, 1987.

Senate amendment

No provision.

Conference agreement

(a) *Clarifying counting of time spent in outpatient settings.*—The conference agreement includes the House provision, with an amendment clarifying that, in order to receive payments under this provision, the hospital must incur all or substantially all of the costs of the residency training in the ambulatory setting. This requirement could be met, for example, if the hospital has an agreement with an independent entity to be legally responsible for reimbursing the entity for the costs the entity incurs for the residency program, subject to the maximum amount recognized as allowable under the Medicare formula enacted in P.L. 99-272, the Consolidated Omnibus Reconciliation Act of 1985.

(b) *Reducing maximum initial residency period.*—The conference agreement does not include the House provision.

14. COST LIMITS FOR HOME HEALTH AGENCIES (SECTION 4502 OF HOUSE BILL; SECTION 613 OF SENATE AMENDMENT)

Present law

Section 1861(v)(1)(L) of the Social Security Act authorizes the Secretary to set limits on home health agency costs which may be recognized as reasonable in the efficient delivery of services. The Secretary is authorized to establish limits for home health agencies at the 75th percentile of the average cost per visit for freestanding home health agencies, or at a lower percentile or comparable or lower limit as the Secretary may determine. The Secretary is also authorized to provide for exemptions and exceptions to these limits as he deems appropriate.

Prior to final regulations published by the Secretary on July 5, 1985, limits to home health agencies were established by regulation at the 75th percentile of the labor-related component of per visit cost and the nonlabor component of per visit cost. Separate limits were established for each type of service (e.g., skilled nursing, home health aide, physical therapy); however they were applied in the aggregate to each home health agency based on its mix of services.

With the regulations published July 5, 1985, HCFA revised the home health limit methodology. For cost reporting periods beginning on or after July 1, 1985, the limits were set at 120 percent of the mean labor-related and nonlabor component of per visit costs. For cost reporting periods beginning on or after July 1, 1986, the limits are set at 115 percent of the mean, and for cost reporting periods beginning on or after July 1, 1987, the limits are to be set at 112 percent of the mean. These regulations also established and applied separate limits for each type of service.

House bill

(a) *Application of cost limits.*—Amends the Secretary's authority to establish limits for home health agency costs to require that limits be applied on an aggregate basis for all home health services, rather than on a discipline-specific basis, with appropriate adjustment for administrative and general costs of hospital-based agencies. The Secretary is also required to base limits on the most recent data available, which may be for cost reporting periods beginning no earlier than October 1, 1983. The Secretary must also take into account the changes in costs of home health agencies for billing and verification procedures that result from the Secretary's changing the requirements for such procedures, to the extent these changes in costs are not reflected in available data.

(b) *GAO study.*—Requires the Comptroller General to study and report to Congress by April 1, 1987, on: (1) the appropriateness and impact on Medicare beneficiaries of applying per visit home health agency cost limits on a discipline-specific basis, rather than on an aggregate basis; and (2) the appropriateness of the percentage limits established in regulation.

Effective date.—Cost reporting periods beginning on or after July 1, 1985.

Requirement for the Secretary to base limits on most recent data available: effective for cost reporting periods beginning on or after July 1, 1985.

Requirement for the Secretary to take into account changes in costs for billing and verification procedures: effective for changes in requirements of Secretary effected before, on, or after July 1, 1985.

Senate amendment

(a) *Application of cost limits.*—Repeals the Secretary's authority to establish home health limits at the 75th percental of the average per visit cost and replaces it with authority to establish, for the cost reporting periods beginning on or after July 1, 1985, limits at 120 percent of the mean of the labor-related and nonlabor component of per visit costs for freestanding home health agencies; for cost reporting periods beginning on or after July 1, 1986, limits at 115 percent of the mean; and for cost reporting periods beginning on or after July 1, 1987, limits at 112 percent of the mean.

Requires that for cost reporting periods beginning on or after Oct. 1, 1986, limits must be applied on an aggregate basis, rather than on a discipline-specific basis, with appropriate adjustment for administrative and general costs of hospital-based agencies.

(b) *GAO study.*—Requires the Comptroller General to study and report to Congress, not later than Sept. 1, 1987, on the appropriateness of applying per visit home health agency cost limits on a discipline-specific basis, rather than on an aggregate basis.

Effective date.—Enactment.

Conference agreement

(a) *Application of cost limits.*—The conference agreement includes the House provision with an amendment changing the effective date to cost reporting periods beginning on or after July 1, 1986.

(b) *GAO study.*—The conference agreement include the House provision.

15. ESTABLISHMENT OF RESEARCH PROGRAM (SECTION 4503 OF HOUSE BILL; SECTION 616 OF SENATE AMENDMENT)

Present law

No provision.

A growing body of research on the utilization of medical services indicates variations in the scope of care furnished to otherwise comparable populations. Such research raises questions that have a bearing on policy decisions affecting the Medicare program. These include questions about the quality of care, the appropriateness of care, and the cost-effectiveness of care being received by Medicare enrollees and the effects of the payment methodologies and quality assurance measures currently employed.

House bill

(a) *Research projects.*—Requires the Secretary to provide for a research program on patient outcomes of selected medical treatments and surgical procedures for the purpose of assessing their appropriateness, necessity, and effectiveness.

The research is required to include (1) assessments of the extent of uncertainty regarding appropriateness; (2) assessments of the appropriateness of admissions or selection criteria; (3) development of

improved measures of patient outcome; (4) evaluation of patient outcome; and (5) efforts to reduce existing levels of uncertainty or disagreement regarding appropriateness.

(b) *Study priorities.*—Requires the Secretary, in selecting treatments and procedures to be studied, to give priority to those medical and surgical treatments and procedures (1) for which data indicate a highly (or potentially highly) variable pattern of utilization among Medicare beneficiaries in different geographic areas; and (2) which are significant (or potentially significant) for purposes of this title in terms of utilization by beneficiaries, length of hospitalization associated with the treatment or procedure, costs to the program and risk involved to the beneficiary.

(c) *Funding levels.*—Makes available, for the purposes of carrying out the research program, (1) from the Federal Hospital Insurance Trust Fund—\$4 million for FY 1987, \$5 million for FY 1988, and \$5 million for FY 1989; and (2) from the Supplementary Medical Insurance Trust Fund—\$2 million for FY 1987, \$2.5 million for 1988, and \$2.5 million for FY 1989.

(d) *Funding distribution.*—Requires not less than 90 percent of each fiscal year's appropriation to be used to fund grants to and cooperative arrangements with, non-Federal research entities. The remaining funds may be used by the Secretary for research by Federal entities and for administrative costs.

(e) *Administration.*—Requires the research program to be run by the National Center for Health Services Research and Health Care Technology. The Center is required to establish application procedures for grants and cooperative agreements. The Center is required to establish peer review panels to review all such applications and all research findings. The Center is required to consult with the Council on Health Care Technology in establishing the scope and priorities for the research program and shall report periodically to the Council on the status of the program.

(f) *HHS cooperation.*—Requires the Secretary to make available data derived from the Medicare care program and any other HHS programs for use in the research program.

(g) *Report to Congress.*—Requires the Center to report to the Senate Committees on Finance and Appropriations and the House Committees on Ways and Means, Energy and Commerce, and Appropriations no later than 18 months after enactment, and annually thereafter, on the research program's findings.

(h) *dissemination of findings.*—Requires the Center, in cooperation with appropriate medical specialty groups, to disseminate the research program's findings as widely as possible, including disseminating the findings, to each peer review organization.

(i) *Permitting services to be provided under research program.*—Permits exceptions to the "reasonable and necessary" coverage exclusion, as necessary to carry out this research.

Effective date.—October 1, 1986.

Senate amendment

(a) *Research project.*—Similar provision, except the research is required to include (1) reorganization of data relating to claims under Part A and B in a manner that facilitates research with respect to patient outcomes; (2) assessments of the appropriateness of admis-

sions and discharges; (3) assessments of the extent of professional uncertainty regarding efficacy; (4) development of improved methods for measuring quality-of-life patient outcomes; (5) model evaluations of patients outcomes, and (6) evaluation of the effects on physician's practice patterns of the dissemination to physicians and peer review organizations of the findings of the research in items (2), (3), (4), and (5) above.

(b) *Study priorities*.—Identical provision.

(c) *Funding levels*.—Makes available, for the purposes of carrying out the research program, (1) from the Federal Hospital Insurance Trust Fund—\$3 million for FY 1987, \$2.75 million for FY 1988, and \$1.75 million for FY 1989; and (2) from the Supplementary Medical Insurance Trust Fund—\$3 million for FY 1987, \$2.75 million for FY 1988; and \$1.75 million for FY 1989.

(d) *Funding distribution*.—Identical provision.

(e) *Administration*.—Similar provision.

(f) *HHS cooperation*.—Identical provision.

(g) *Report to Congress*.—Identical provision.

(h) *Dissemination of findings*.—Identical provision.

(i) *Permitting services to be provided under Research Program*.—Identical provision.

Effective date.—October 1, 1986.

Conference agreement

(a) *Research projects*.—The conference agreement includes the Senate amendment with a modification deleting the role of the Assistant Secretary for Planning and Evaluation.

(b) *Study priorities*.—The conference agreement includes the Senate amendment.

(c) *Funding levels*.—The conference agreement includes the House provision.

(d) *Funding distribution*.—The conference agreement includes the House provision.

(e) *Administration*.—The conference agreement includes the House provision.

(f) *HHS cooperation*.—The conference agreement includes the House provision.

(g) *Report to Congress*.—The conference agreement includes the House provision.

(h) *Dissemination of findings*.—The conference agreement includes the House provision.

(t). *Permitting services to be provided under Research Program*.—The conference agreement includes the House provision.

16. CIVIL MONETARY PENALTY AND EXCLUSION PROVISIONS (SECTION 4505 OF HOUSE BILL)

Present law

Practitioners and institutions who present false or certain other improper claims or requests for reimbursement under the Medicare, Medicaid, or Maternal and Child Health Services Block Grant programs are, in addition to potential criminal penalties, subject to civil monetary penalties of up to \$2,000 for each item or service and, in lieu of damages, an assessment of up to twice the amount

claimed. Civil money penalty proceedings are prosecuted by the Inspector General of the Department of Health and Human Services before an administrative law judge; provider's may appeal adverse determinations to the appropriate U.S. Circuit Court of Appeals. In addition, individuals who have been convicted of criminal offenses related to their participation in Medicare and Medicaid are subject to exclusion from both programs; these individuals are entitled to an administrative hearing and, if the agency upholds the Inspector General's decision to exclude, judicial review.

House bill

(a) Collateral estoppel effect of prior Federal criminal convictions.—In a proceeding to bar a physician or other individual from participating in Medicare or Medicaid which is against an individual who has been convicted (whether upon a verdict after trial or upon a plea of guilty or *nolo contendere*) of a Federal crime charging fraud or false statements, and which involves the same transaction as in the criminal action, the individual cannot relitigate (i.e., is estopped from denying) the essential elements of the criminal offense in a subsequent civil case including a civil monetary penalties case.

(b) Authority of hearing officer to sanction misconduct.—The official conducting such a hearing may sanction a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an action, or other misconduct that would interfere with the speedy, orderly, or fair conduct of the hearing.

Requires the sanction to reasonably relates to the severity and nature of the failure or misconduct. The sanction may include: (1) in the case of refusal to provide or permit discovery, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established; (2) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense; (3) striking pleadings, in whole or in part; (4) staying the proceedings; (5) dismissal of the action; (6) entering a default judgment; (7) ordering the party or attorney to pay attorney's fees and other costs caused by the failure or misconduct; and (8) refusing to consider any motion or other action which is so filed in a timely manner.

(c) Clarification of exclusion authority for certain offenders.—Considers a physician or other individual to have been "convicted" of a criminal offense: (1) when a judgment of conviction has been entered against the physician or individual by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged; (2) when there has been a finding of guilt against the physician or individual by a Federal, State, or local court; (3) when a plea of guilty or *nolo contendere* by the physician or individual has been accepted by a Federal, State, or local court; and (4) when the physician or individual has entered into participation in a first offender or other program when judgment of conviction has been withheld.

Effective date.—(a) Applies on enactment, without regard to when a criminal conviction was obtained; (b) applies to failures or misconduct occurring on or after the date of enactment; and (c) ap-

plies to judgments entered, findings made and pleas entered before, on or after the date of enactment (except for (4) which applies to participation in a program entered into on or after the date of enactment).

Senate amendment

No provision.

Conference agreement

(a) *Collateral estoppel effect of prior Federal criminal convictions.*—The conference agreement includes the House provision.

(b) *Authority of hearing officer to sanction misconduct.*—The conference agreement includes the House provision.

(c) *Clarification of exclusion authority for certain offenders.*—The conference agreement includes the House provision.

17. HOSPITAL PROTOCOLS FOR ORGAN PROCUREMENT AND STANDARDS FOR ORGAN PROCUREMENT AGENCIES (SECTION 4508 OF HOUSE BILL)

Present law

Current law does not include requirements with regard to hospitals and organ procurement protocols, or with respect to certification standard for organ procurement agencies.

The Task Force on Organ Transplantation, created by the National Organ Transplant Act (P.L. 98-507), found that opportunities for obtaining organs were lost due to shortcomings in the present organ procurement process. The Task Force recommended legislation requiring that hospitals establish protocols for encouraging organ and tissue donation and requiring certification standards for organ procurement agencies.

House bill

(a) *Hospital protocols.*—Requires that the Secretary provide that no hospital may participate in Medicare or Medicaid unless the hospital has established protocols for encouraging organ and tissue donation.

(b) *Criteria and certification of organ procurement agencies.*—Would prohibit payment under Medicare or Medicaid with respect to costs of procuring organs, by an organ procurement organization that is not qualified under section 317(b) of the Public Health Service Act (or does not meet the standards to be qualified), and that has not been certified (and recertified at least every 2 years) as meeting the standards established by the Association of Independent Organ Procurement Agencies.

Effective date.—Applies to hospitals as of July 1, 1987, and to the costs of organs procured on or after January 1, 1988.

Senate amendment

No provision.

Conference agreement

(a) *Hospital protocols.*—The conference agreement includes the House provision, with amendments. In addition to establishing protocols for making a routine inquiry, hospitals would have to notify

the local organ procurement agency when a potential organ donor is identified. The conferees intend for the hospital and the organ procurement agency to cooperate in counseling and procurement activities.

Those hospitals in which organ transplants are performed would also have to be members of the national organ transplant network established under the National Organ Transplant Act of 1984, and to comply with the policies of that network regarding the allocation of organs.

The requirement that these procedures be followed in cases of a potential tissue donor who is not also a potential organ donor has been removed. Instead, a definition of "organ" is added, which provides the Secretary discretion to extend these requirements to any tissue that the Secretary finds to be appropriate. This provision encourages tissue donation whenever the hospital has identified a potential organ donor. The hospital is required, under the conference agreement, to notify the organ procurement agency designated by the Secretary to serve that area. In turn, the organ procurement agency, under the terms of the conference agreement and the requirements of the National Organ Transplant Act, is required to have cooperative arrangements with tissue banks, in order to be designated by the Secretary as the organ procurement agency for the area.

(b) Criteria and Certification of Organ Procurement Agencies.—The conference agreement includes the House provision with an amendment. In order for its costs to be reimbursed by Medicare, an organ procurement agency would have to comply with the requirements of section 371(b) of the Public Health Service Act, which were enacted as part of the National Organ Transplant Act of 1984. The alternative of meeting standards established by the Association of Independent Organ Procurement Agencies is deleted.

The conference agreement also adds several other requirements that agencies must meet. First, they must meet performance standards set by the Secretary, respecting the quality or competence of the services performed by the agency and the volume of organs procured.

Second, with respect to all organs within their control, they must comply with the policies established by the national organ transplant network regarding the allocation of organs, irrespective of whether the organ is placed through the network or is placed without the assistance of the network. This provision reflects the conferees' concern about wastage and criticisms of the allocation of available organs.

The conferees understand that the national network will have policies requiring that separate lists of potential recipients be maintained for U.S. residents and foreign nationals, and that all potential recipients on the first list be reviewed for an acceptable match between organ and recipient before the organ is offered to someone on the second list or exported out of the country. It is also the conferees' understanding that these policies require there to be documentation that an acceptable match was not available on either list before the organ was offered for export. The conference agreement is premised on these policies being retained and fol-

lowed, and on all allocations being made on the basis of criteria established by the network.

Medicare payments will be made for organ procurement agencies only for those agencies specifically designated by the Secretary, and only one agency may be designated in each service area.

18. MEDICARE AS SECONDARY PAYER; COVERAGE REQUIREMENTS FOR CERTAIN OTHER PAYERS (SECTION 611 OF SENATE AMENDMENT)

Present law

TEFRA required employers to offer their employees ages 65 through 69 the same group health plans to employees under age 65. When the employee age 65 to 69 elects such coverage, Medicare becomes the secondary payer. The beneficiary retains the right not to elect such coverage and to be covered only by Medicare. DEFRA extended this provision to include beneficiaries covered under a working spouse's employer-based group health insurance plan when the working spouse is under age 65. COBRA further extended the provision to apply to the working aged and spouses over age 69.

House bill

No provision.

Senate amendment

Recodifies current law with respect to secondary payer provisions and amends the Social Security Act to provide that Medicare would be the secondary payer for all Medicare beneficiaries (including disabled and those who buy into Medicare) who elect to be covered by employment based health insurance as a current employee (or family member of such employee) of a large employer. This provision would explicitly include under the secondary payer provision those persons with group health coverage who are the employer, former employees under age 65, individuals associated with the employer in a business relationship, or members of the families of any such persons.

Uniform rules are established as to the benefits Medicare pays when other payers are primary but do not pay the full charge. Payments under workers compensation or liability or related insurance are counted toward the Medicare deductible, as provided under current law for other types of primary payers.

The secondary payer provisions are enforceable through private action or action brought by the Federal Government (with double damages payable). In addition, a tax is imposed on employers and employee organizations that contribute to plans that do not conform with the secondary payer provisions. The tax is 25 percent of the employer's or employee organization's annual contributions to nonconforming group health plans.

Federal Medicaid payments to a State would be reduced by an amount equal to 25 percent of the group health plan expenses of a State that does not comply with the secondary payer provision.

Conforming amendments are made to the section relating to special enrollment periods and premium penalties for part B of Medicare for individuals covered under employer based group health plans.

Effective date.—The special enrollment period and premium penalty provisions apply to enrollments occurring on or after October 1, 1986, and premiums for months beginning on or after October 1, 1986. All other provisions apply to items and services furnished in calendar quarters beginning on or after October 1, 1986.

Conference agreement

The conference agreement includes the Senate amendment with modifications. The provision which requires that medicare be secondary payer for disabled beneficiaries who elect to be covered under employer-based health insurance as a current employee (or family member of such employee) would only apply to employers with 100 or more employees. The provision would sunset October 1, 1991. The agreement would require the Secretary to study the impact of this provision. The agreement includes additional modifications to (1) retain enforcement of the requirements related to coverage of the working aged under the Age Discrimination Act, (2) add a private right of action to enforce the provision for the aged, and (3) eliminate reductions in Medicaid funds as a penalty for States which do not comply.

19. COVERAGE OF SERVICES OF NURSE ANESTHETISTS (SECTIONS 4524 AND 10207 (A) OF HOUSE BILL)

Present law

Payments for services of certified registered nurse anesthetists (CRNAs) employed by hospitals are made to the hospital on a reasonable cost basis and are temporarily excluded from the definition of operating costs under PPS. For services of CRNAs employed by anesthesiologists, the anesthesiologist is paid on a reasonable charge basis as if he had performed the service. Physicians who provide medical direction for CRNAs employed by a hospital receive an adjusted reasonable charge payment. Provisions relating to payment for services of hospital-employed and physician-employed CRNAs are both effective for cost reporting periods beginning on or after October 1, 1984, and before October 1, 1987.

House bill

(a) Payment extension.—

Section 10207(a).—Extends current payment provisions for the services of CRNAs hospital-employed for cost-reporting periods beginning before October 1, 1988. [Note: See item 23(c) for related provision requiring study of prospective payment for radiology, anesthesia, and pathology services.]

Section 4524.—No provision.

(b) Direct reimbursement for services of a registered nurse anesthetist.—

Section 10207(a).—No provision.

Section 4524.—Authorizes direct reimbursement for anesthesia services and related care furnished by a registered nurse anesthetist which he/she is legally authorized to perform in the State. The term registered nurse anesthetist is defined as a registered nurse licensed by the State who meets such education, training, and other requirements relating to anesthesia

services and related care as the Secretary may prescribe. The Secretary may use the same requirements as those established by a national organization for the certification of nurse anesthetists.

Specifies that nothing in this section shall contravene provisions of State law relating to the practice of medicine or nursing or State law requirements or institutional requirements regarding the administration of anesthesia and its medical direction or supervision.

Authorizes direct reimbursement for services equal to 80 percent of the reasonable charge for such services. The reasonable charge is the amount determined by the Secretary to be consistent with efficient and high quality anesthesia services taking into account the prevailing rate for such services. However, the reasonable charge must be adjusted to the extent necessary to ensure that the total amount paid for such services by Medicare in any fiscal year may not exceed the total amount which would have been paid if such services were included as inpatient hospital services and paid for under Part A, in the same manner as payment was made in fiscal year 1986, adjusted to take into account changes in prices and technology relating to the administration of anesthesia.

Requires the Secretary to adjust the reasonable charge for medical direction of services of registered nurse anesthetists to the extent necessary to ensure that the total amount paid for medical direction and services would not exceed the amount which would have been paid in the absence of this provision. If the adjustment results in a reduction in the reasonable charge for a non-participating physician, such physician may not charge more than 125 percent of the adjusted prevailing charge; if the physician charges more, the physician would be required to refund the excess to the individual. If the physician knowingly and willfully imposes charges or fails to make required refunds, the Secretary could impose sanctions.

Effective date.—Section 10207(a).—Enactment. Section 4524.—Applies to items and services furnished on or after October 1, 1987.

Senate amendment

No provision.

Conference agreement

(a) *Payment extension.*—The conference agreement includes the House provision contained in Section 10207(a).

(b) *Direct reimbursement for services of a certified registered nurse anesthetist.*—The conference agreement includes the House provision contained in Section 4524 with a modification as follows. The conference agreement authorizes payments to be made in an amount equal to the lower of 80% of a fee schedule established by the Secretary or 80% of the actual charge. The Secretary could utilize time units, or a system of base and time units, or another appropriate methodology, in establishing the schedule. The Secretary is permitted to establish a nationwide fee schedule or to adjust the fee schedule for geographic areas. Initially, the fee schedule would be established at a level based on the costs of anesthesia services provided by certified registered nurse anesthetists determined from audited cost data from cost reporting periods ending in FY 85. The

fee schedule amount would be adjusted annually by the change in the Medicare economic index.

The fee schedule amount would be adjusted to the extent necessary to ensure that the total amount paid by Medicare (plus applicable coinsurance amounts) in 1989 for certified registered nurse anesthetist services would equal the amount which would be paid under part A for the same volume of CRNA services in the absence of this provision. The Secretary would also be permitted to adjust payment levels in 1989 and 1990 for CRNA services and for medical direction provided by physicians (or both), in order to assure that payments made under this provision for both CRNA services and medical direction do not exceed those that would be made in the absence of this provision. The Secretary could do this by adjusting time or base units, or by any other means. The conferees recognize that it will be difficult to document the volume and cost of CRNA services currently being reimbursed under Part B and to estimate what total Medicare payments would be in the absence of this provision. The Secretary is expected to use the best estimates available for this purpose.

In the case of nonparticipating physicians whose actual charges have been reduced pursuant to this provision, a special limit on maximum allowable actual charges (MACC) would apply. For the first year the reduction is in effect, the maximum allowable actual charge for the service would equal 125% of the reduced prevailing charge amount plus one-half of the difference between the physician's actual charge in the preceding period and 125% of the reduced prevailing charge amount. In the second year, the special maximum allowable charge for the service would equal 125% of the reduced prevailing charge amount.

Certified registered nurse anesthetists would be required to accept assignment for all Medicare services and civil monetary penalties could be imposed for violations of this requirement. Payments could be made directly to the certified registered nurse anesthetist. Alternatively, the hospital or physician could bill for and receive payment for these services where an employment relationship or contract so stipulates. The hospital or physician could not bill more for certified registered nurse anesthetist services than the amount the CRNA could bill directly.

The conference agreement specifies that the fee schedule would apply to items and services furnished on or after January 1, 1989. The current cost pass through for hospital-employed CRNAs would be extended to that date, irrespective of the hospital's cost reporting period. The conferees intend that the Secretary will extend the limitation on physicians' rights to bill for inpatient services provided by CRNAs whom they employ, as provided under current law until January 1, 1989.

II. MEDICARE PROVISIONS (PART B)

20. EXTENSION OF PREMIUM PAYMENT PROVISION THROUGH 1989 (SECTION 10231 OF HOUSE BILL; SECTION 1001(C) OF SENATE AMENDMENT)

Present law

Under the original Medicare law, beneficiary premiums paid for 50 percent of the program cost of part B with the remaining 50 percent financed by Federal general revenues. However, between 1974 and 1982 the law limited the percentage increase in the part B premium to the percentage increase in Social Security cash benefits payments. By 1982, beneficiary premiums paid for approximately 25 percent of program costs.

TEFRA, as amended by the Social Security Amendments of 1983 (P.L. 98-21), specified that enrollee premiums in 1984 and 1985 would be allowed to increase to amounts necessary to produce premium income equal to 25 percent of program costs for elderly enrollees. If there is no Social Security COLA, the monthly premium would not be increased in that year. If the amount of a premium increase is greater than the Social Security COLA, the premium increase is to be reduced so as to avoid a reduction in the individual's Social Security check. Disabled enrollees pay the same premiums, though the per capita cost of services to these enrollees is higher. DEFRA extended this provision for 1986 and 1987, COBRA extended this provision through 1988. Beginning January 1, 1989, the premium calculation reverts to the earlier method.

House bill

(a) *One year extension.*—Extends the current 25 percent payment provision for one additional year, through calendar year 1989.

(b) *Technical conforming change.*—No provision.

Effective date.—Enactment.

Senate amendment

(a) *One year extension.*—No provision.

(b) *Technical conforming change.*—Makes technical clarifying changes in provision reducing the premium increase where necessary to avoid a reduction in the individual's Social Security checks.

Effective date.—Applies with respect to monthly premiums for months after December 1986.

Conference agreement

(a) *One year extension.*—The conference agreement does not include the House provision.

(b) *Technical conforming change.*—See Item 1, Part I, Income Security Provisions.

21. PAYMENTS FOR PHYSICIANS' SERVICES (SECTIONS 10232 (A-D, AND F-J) AND SECTION 4525 OF HOUSE BILL; SECTIONS 621 (B-C) AND 622 OF SENATE AMENDMENT)

Present law

Payments are made to physicians on the basis of reasonable charges. The reasonable charge for a service is the lowest of the actual charge, the physician's customary charge for the service or the prevailing charge for the service in the community. The prevailing charge for a service is the lower of the 75th percentile of customary charges for the service in the area, or the maximum allowed prevailing charge, which is the unadjusted prevailing charge in a base year increased by the Medicare economic index (MEI).

DEFRA froze physician fees for the 15-month period July 1, 1984 through September 30, 1985. P.L. 99-107, as amended, and COBRA extended this freeze through April 30, 1986 for participating physicians and December 31, 1986 for non-participating physicians.

Since July 1, 1984, the actual charges of non-participating physicians have been subject to a freeze. Violations have been subject to sanctions. The freeze expires on December 31, 1986.

On May 1, 1986, participating physicians received an increase in prevailing charges based on the MEI for 1986 plus an additional one percentage point. The one percentage point increase is temporary and will not be included after December 31, 1986. Participating and non-participating physicians will receive a prevailing charge increase each year beginning on January 1987. The increase for non-participating physicians is to be lagged and will be based on the MEI for the preceding year.

The MEI, expressed as a maximum allowable percentage increase, has been tied to economic indexes reflecting changes in physician operating expenses and earnings levels. On August 12, 1986, the Administration has by regulation revised the calculation of the MEI to account for an adjustment to the housing cost component, which the Administration believes to be historically overstated. The index would be computed retroactively using the rental equivalence housing component of the CPI as a substitute for the home ownership approach.

COBRA required the Secretary, with the advice of the newly established Physician Payment Review Commission, to develop a relative value scale for physician payments. The Secretary is required to complete the development of the RVS and report to Congress on its development by July 1, 1987. The report is to include recommendations concerning its potential application to Medicare on or after January 1, 1988.

(a) Maximum allowable prevailing charges.—

Section 10232.—On January 1, 1987, all physicians will receive an increase in prevailing charges based on the percentage increase in the Medicare economic index (MEI) for services provided in 1987. The increase will apply to the maximum allowable prevailing charges of participating and nonparticipating physicians respectively in effect during the 8-month period ending on December 31, 1986. The Secretary is required to treat the maximum allowed prevailing charges recognized for participating and nonparticipating physicians respectively

during such 8-month period as having been justified by economic changes. In years subsequent to 1987, the maximum allowed prevailing charges of participating and nonparticipating physicians is to be increased by the MEI increase factor applicable for services provided during the year.

Section 4525.—Specifies that the one percentage point increase for participating physicians permitted on May 1, 1986 is built into the MEI base for future calculations. Allows an MEI update for all participating physicians and all assigned claims submitted by nonparticipating physicians. Limits increases in prevailing charges for unassigned claims to 1 percent in 1987.

(b) Bonus for participating physicians.—

Section 10232.—Provides that in applying the percentage increase in the MEI for physicians' services furnished by participating physicians during each year after 1986, the Secretary shall provide for a bonus of one percentage point in the percentage increase otherwise determined. Such a bonus for each year will apply to physicians' services furnished only during the year and not in the calculation of payments for any subsequent year.

Section 4525.—No provision.

(c) Limit on actual charges for nonparticipating physicians.—

Section 10232.—The current freeze on actual charges of nonparticipating physicians would be replaced by a role of increase limit. In 1987, nonparticipating physicians could increase their actual charges above levels in effect during the calendar quarter beginning April 1, 1984 by an amount equal to the MEI for 1987 plus one percentage point. For nonparticipating physicians without actual charges for a procedure during the calendar quarter beginning April 1, 1984, the limit is the 50th percentile of customary charges (weighted by frequency of the procedure) for the procedure performed by nonparticipating physicians in the locality during the 12-month period ending June 30, 1986 increased by the MEI for 1987 plus one percentage point. In future years, the limit is the maximum allowed charge permitted for the previous year increased by the percentage increase in the MEI. If the physician knowingly and willfully bills for actual charges in excess of permitted charges, the Secretary may apply sanctions for noncompliance. Carriers are required to provide available information to nonparticipating physicians to enable them to determine maximum allowed charges.

In calculating customary charges for services furnished on or after January 1, 1988, the Secretary shall not recognize any increases in actual charges in excess of these limits.

Section 4525.—Similar provision with respect to monitoring of charges and application of sanctions. Nonparticipating physicians could increase their actual charges in 1987 by the percentage increase in the MEI for assigned claims and only by 1 percent for nonassigned claims. In calculating customary charges for services furnished during 1988 and 1989, the Secretary shall not recognize any increase in actual charges in excess of the limits.

(d) Medicare economic index (MEI).—

Section 10232.—Prohibits the Secretary from revising the MEI in a manner that provides for any period before January 1, 1985, for the substitution of a rental equivalence or rental substitution factor for the housing component of the consumer price index.

Section 4525.—Identical provision.

(e) *Reasonable charge limitations.*—(See item 21, Inherent Reasonableness.)

(f) *Recruiting.*—

Section 10232.—Requires carriers to implement programs to recruit and retain physicians as participating physicians, including educational and outreach activities and the use of professional relations personnel to handle billing problems for participating physicians. Carriers are also required to implement programs to familiarize beneficiaries with the participating physician program and to assist them in locating participating physicians. The Secretary is required to provide a system for measuring carriers' performance with respect to these responsibilities or those specified under section 1842(h) of the Social Security Act. An incentive pool, equal to 1 percent of total payments to carriers for claims processing, will be available to reward carriers for their success in increasing the percentage of participating physicians in the carrier's service area.

Section 4525.—No provision.

(g) *Directories of participating physicians.*—

Section 10222.—Requires the Secretary to provide that each appropriate area directory is sent to each Part B beneficiary residing in the area and that an appropriate number of copies is sent to hospitals in the area. The copies are to be sent free of charge.

Requires each directory to provide alphabetical listings for: (1) all participating physicians in the area; and (2) locality and specialty of such physicians.

Section 4525.—No provision.

(h) *Prohibiting unassigned billing of services determined to be medically unnecessary by a carrier.*—

Section 10232.—Provides that, where a physician has provided services on a nonassigned basis which are determined by a peer review organization or carrier to be unnecessary, the physician is required to refund any amounts collected from the beneficiary within 30 days after receiving a notice that the services were unnecessary or within 15 days after receiving notice of an adverse determination upon reconsideration or appeal. A refund would not be required if: (i) the physician did not know and could not reasonably have been expected to have known that the services would be found to be unnecessary; or (ii) the beneficiary was informed in advance that Medicare payment would not be made for a specific service and agreed to pay for the service. Physicians who knowingly and willfully fail to make required refunds on a timely basis would be subject to civil money penalties and/or exclusion from the Medicare program. Carriers and peer review organizations would be

required to send denial notices based on medical necessity determinations to the physician and the beneficiary.

Section 4525.—No provision.

(i) *Maintenance and use of participating directories by hospitals.*—

Section 10232.—Amends Medicare participation agreements to require hospitals to make available directories of participating physicians and, where referral is made to a nonparticipating physician, inform the beneficiary of such fact. Wherever practicable, the hospital must identify at least one qualified participating physician.

Section 4525.—No provision.

(j) *Submission and disclosure of information on unassigned claims.*—

Section 10232.—Provides that where the actual charge on an unassigned elective surgical procedure exceeds \$500, the physician is required to disclose to the individual in writing, the estimated charge, the estimated approved charge, and the excess of the physician's actual charge over the approved charge. A physician failing to comply with this requirement would be required to refund payments received in excess of the Medicare approved charge. Knowing and willful failures to make required refunds would be subject to civil money penalties and/or exclusion from Medicare.

Section 4525.—No provision.

(k) *HCFA common procedure coding system.*—No provision.

(l) *Recommendations for relative value scale (RVS).*—No provision.

Effective date.—*Section 10232:* (a) and (c) apply to services furnished on or after January 1, 1987. (b) and (d) are effective on enactment. (f) applies to carrier contracts as of October 1, 1987; carrier bonus payments shall be first paid not later than April 1, 1988, to reflect performance of carriers during November 1987. (g) applies for distribution of directories to beneficiaries for 1988 directories; organization of directories applies to 1987 directories. (h) applies to services furnished on or after October 1, 1987. (i) applies to agreements as of October 1, 1987. (j) applies to surgical procedures performed on or after October 1, 1987.

Section 4525: (a) and (c) applies to services furnished on or after January 1, 1987. (d) effective on enactment.

Senate amendment

(a) *Maximum allowable prevailing charges.*—No provision.

(b) *Bonus for participating physicians.*—No provision.

(c) *Limit on actual charges for nonparticipating physicians.*—No provision.

(d) *Medicare economic index (MEI).*—Provides that the adjustment of the MEI as proposed by the Administration would be made in two stages, with one-half of the adjustment becoming effective January 1, 1987, and the other half January 1, 1988. The Secretary is required to utilize the rule-making process for proposed changes in the methodology, basis, or elements of the MEI.

(e) *Reasonable charge limitations.*—(See item 21, Inherent Reasonableness.)

(f) *Recruiting*.—No provision.

(g) *Directories of participating physicians*.—No provision.

(h) *Prohibiting unassigned billing of services determined to be medically unnecessary by a carrier*.—No provision.

(i) *Maintenance and use of participating directories by hospitals*.—No provision.

(j) *Submission and disclosure of information on unassigned claims*.—No provision.

(k) *HCFA common procedure coding system*.—Requires by July 1, 1987, the consolidation of the payment methodology under HCFA's Common Procedures Coding System (HCPCS) and mandates its use for hospital outpatient services by the same date. Carriers and intermediaries are required to report services and claims using HCPCS by January 1, 1988.

Recommendations for relative value scale (RVS).—Requires the Secretary in making recommendations for application of an RVS to: 1) develop and assess an appropriate index to reflect justifiable geographic variations in practice costs without exacerbating the geographic maldistribution of physicians; and 2) assess the advisability and feasibility of developing an appropriate adjustment to assist in attracting and retaining physicians in medically underserved areas. The Secretary is to take into account recommendations of the Physician Payment Review Commission. The Secretary is to develop an interim geographic index by July 1, 1987, and collect data for refining the index by December 31, 1989. The date of the Secretary is required to report on the RVS is deferred to July 1, 1989. The potential application date of the RVS is deferred until after December 31, 1989.

Effective date.—Enactment.

Conference agreement

(a) *Maximum allowable prevailing charges*.—The conference agreement includes the House provision with amendments. All physicians would receive an increase in their prevailing charges equal to 3.2% effective January 1, 1987. In 1987 and future years, the percent increase in the MEI would be applied to the maximum allowable prevailing charges for participating and nonparticipating physicians respectively in effect on December 31 of the previous year.

The conference agreement makes permanent the current differential in the prevailing charges of participating and nonparticipating physicians. In other words, the prevailing charges for nonparticipating physicians would equal 96% of the prevailing charges for participating physicians. In future years, participating and nonparticipating physicians would receive the same percentage increase based on the percentage increase in the medicare economic index (MEI) for the year. This provision replaces the 1-year lag in prevailing charges for nonparticipating physicians contained in the Consolidated Omnibus Budget Reconciliation Act of 1985.

The conference agreement does not include the House provision that would pay a higher rate for assigned claims of nonparticipating physicians.

(b) *Bonus for participating physicians*.—The conference agreement does not include the House provision that would provide a

new bonus for participating physicians in addition to the differential in effect during the 8-month period ending December 31, 1986.

(c) *Limit on actual charges for nonparticipating physicians.*—The conference agreement includes the House provision with a modification as follows. In the case of a nonparticipating physician whose actual charge for a service in the previous year equals or exceeds 115% of the prevailing charge for nonparticipating physicians for the service in the current year, the maximum allowable actual charge (MAAC) is 101% of the physician's actual charge for the previous year.

A nonparticipating physician whose actual charge for a service in the previous year is less than 115% of the current year prevailing charge for nonparticipating physicians could increase his/her actual charge in the current year by the greater of: (i) 1% above the physician's previous year actual charge or (ii) an amount based on a comparison between the physician's MAAC for the previous year and 115% of the current year prevailing charge. Under clause (ii), the MAAC for the current year equals the previous year MAAC increased by a fraction of the difference between 115% of the current year prevailing and the previous year MAAC. The applicable fractions are one-quarter, one-third, one-half, and one for 1987, 1988, 1989, and 1990 respectively.

Thus, for calendar year 1987, the physician's MAAC for 1986 is compared with the prevailing charge for nonparticipating physicians in 1987. The 1987 MAAC is equal to the 1986 MAAC plus one-quarter of the difference between 115% of the 1987 prevailing charge amount and the 1986 MAAC. For example, if a physician's 1986 MAAC is \$100 and 115% of the 1987 prevailing charge amount is \$124, the 1987 MAAC for that physician for that service is \$106 [$\$100 + 0.25 (\$124 - \$100)$].

In future years a similar calculation is made. In 1988, the MAAC equals the 1987 MAAC plus one-third of the difference between 115% of the nonparticipating physicians' 1988 prevailing charge amount and the 1987 MAAC. In 1989, the MAAC equals the 1988 MAAC plus one-half of the difference between 115% of the 1989 prevailing charge amount and the 1988 MAAC. In 1990 the MAAC equals 115% of the 1990 prevailing charge. The limitation on maximum allowable actual charges expires on December 31, 1990 or one year after submission by the Secretary to the Congress of the required report on relative value scales, whichever occurs earlier.

Because of the July 1, 1984 through December 31, 1986 freeze on actual charges of nonparticipating physicians, a nonparticipating physician's 1986 MAAC equals the physician's April 1 through June 30, 1984 base period charges. The 1986 MAAC for a nonparticipating physician who does not have an actual charge for a service during the April to June 1984 base period is set at the 50th percentile of customary charges for the service as provided by nonparticipating physicians in the locality during the 12 month period ending on June 30, 1986. A similar rule applies in future years.

The conference agreement does not require a physician to have a single actual charge for a service. Instead, a physician may have a range of actual charges above the MAAC provided that there are offsetting charges below the MAAC. However, if the weighted average of the physician's actual charges for a procedure during a

period of time exceeds the MAAC, the physician may be subject to civil monetary penalties.

The conference agreement requires that the carriers provide each nonparticipating physician with a list of MAACs for the procedures most commonly provided by the physician at the beginning of each year. It is expected that the list should be sent to each nonparticipating physician no later than March 1 for 1987 and no later than February 1 for subsequent years. While the conferees believe that it is important to provide this information, failure to receive MAACs at the beginning of a year should not be a defense in any action against a physician for failure to abide by the limits.

(d) Medicare economic index.—The conference agreement includes the House provision with amendments. The MEI update for 1987 is set by statute at 3.2%. The Secretary would be required to determine the percentage increase in the MEI on an annualized basis comparing appropriate year-to-year economic changes. For 1988, the MEI update should reflect economic changes comparing the period July 1, 1986 through June 30, 1987 with the period July 1, 1985 through June 30, 1986. (This comparison reflects the same comparisons that would be made under the current MEI methodology.)

The Secretary would be prohibited from revising the cumulative MEI on a retrospective basis. This is accomplished (i) by requiring the Secretary to recognize that the maximum allowable prevailing charges for participating physicians in effect on December 31, 1986 were justified by economic changes and (ii) by requiring use of the annualized MEI comparing appropriate year-to-year economic changes.

The Secretary would be required to conduct a study of the MEI to ensure that the index reflects economic changes in an appropriate and equitable manner for physicians providing service to medicare beneficiaries. The Secretary would be required to consult appropriate experts in conducting the study.

The Secretary would be precluded from changing the methodology used to determine the MEI until completion of the study and publication of a final notice changing the methodology. The new methodology must not reflect retrospective historical adjustments in the cumulative index. The Secretary would be required to publish a proposed notice and allow not less than 60 days for public comment. Until publication of the final notice, the Secretary would be required to use the general methodology that was used to calculate the MEI that was published in the Federal Register on September 30, 1985.

(e) Reasonable charge limitations.—(See item 22.)

(f) Recruiting.—The conference agreement includes the House provision.

(g) Directories of participating physician.—The conference agreement includes the House provision with an amendment. Annually, a letter reminding beneficiaries of the participating physician program and offering a copy of the participating physician directory would be sent to each beneficiary in the beneficiary's Social Security check. The letter would indicate that a free copy of the directory would be sent upon request and the beneficiary would be directed to contact his local Medicare carrier or social security office.

(h) *Prohibiting unassigned billing of services determined to be medically unnecessary by a carrier of PRO.*—The conference agreement includes the House provision with an amendment specifying that the requirement only applies to covered services with are determined to have been medically unnecessary in the particular case.

(i) *Maintenance and use of participating directories by hospitals.*—The conference agreement includes the House provision.

(j) *Submission and disclosure of information on unassigned claims.*—The conference agreement includes the House provision with an amendment which indicates that the information is not to be used as the basis for or evidence in a civil suit.

(k) *HCFA common procedure coding system.*—The conference agreement includes the Senate amendment with amendments. The Secretary would be required to consult with appropriate experts including physicians and health economists to provide assistance in determining which procedure codes should be consolidated (and in what manner) for payment purposes. The Secretary would be required to publish a proposed notice in the Federal Register and allow 60 days for public comment.

(l) *Recommendations for relative value scale.*—The conference agreement includes the Senate amendment.

22. INHERENT REASONABLENESS; PAYMENTS FOR CATARACT SURGERY (SECTION 10232 (E), SECTION 4526 AND SECTION 4527 OF HOUSE BILL; SECTION 621 (A) OF SENATE AMENDMENT)

Present law

(a) *Reasonable charge limits inherent reasonableness.*—COBRA required the Secretary to promulgate regulations which specify explicitly the criteria of “inherent reasonableness” which are to be used for determining Medicare payments. On August 11, 1986, the Administration by regulation published “inherent reasonableness” guidelines.

There is no authority under current law for the Secretary to limit the actual charges billed by a physician or supplier to protect the beneficiary against increased expenses when Medicare payments are reduced.

(b) *Payments for cataract surgery.*—Payments for cataract surgery are made on the basis of reasonable charges. Payments for anesthesia services are based on a method that combines base units (with values assigned to each procedure) and time units.

If the Secretary were to reduce Medicare payments for these services, under “inherent reasonableness,” he would not have authority to limit the actual charge billed to the patient.

House bill

(a) *Reasonable charge limits/inherent reasonableness.*—
Section 10232.—

(i) Specifies that for nonphysicians’ services, the inherent reasonableness limitation may be used only by carriers and only in calculating prevailing charges for an item or service by eliminating charges for specific items or services in specific instances in which the charges, in comparison

with the charges for similar items and services, are grossly excessive or deficient.

(ii) Prohibits the Secretary, through regulations, guidelines, instructions or otherwise, from requiring carriers to reduce payment amounts for specific items or services for which the Secretary had made a specific determination that the payment amounts or charges are excessive.

(iii) Requires the Secretary, after consultation with the Physician Payment Review Commission, to submit to Congress by April 1, 1987, recommendations concerning payment-reductions for overpriced items and services. The recommendations are to include the specific payment reductions recommended and measures to assure that reductions in payment do not result in corresponding increases in out-of-pocket costs to Medicare beneficiaries.

Section 4526.—

(i) Requires the Secretary before exercising the authority to adjust reasonable charges, to make specific findings. Specifies that the Secretary may compare: charges and resource costs for related procedures; charges and resource costs for the procedure over a period of time; charges for procedures in different geographic areas; and charges and allowed payments by Medicare and other payers. An adjustment on the basis of a comparison of prevailing charges in different localities may only be made if the Secretary determines that the prevailing charge allowed in one locality is grossly out of line with prevailing charges allowed in other localities after accounting for differences in practice costs. Specifies that the Secretary, in determining whether to adjust payment rates, shall consider the following: potential impacts on quality, access and beneficiary liability of the adjustment; likely effects on assignment rates, reasonable charge reductions on unassigned claims, and participation rates of physicians; proportion of such procedures for which payment is available under Medicare; and the prevailing charge of other third-party payers for the procedure.

(ii) Specifies that the Secretary is required to consult with the Physician Payment Review Commission with respect to a proposed adjustment, and after such consultation, publish a notice of the proposed adjustment and allow for public comment. The final notice must explain the factors and data taken into consideration in making the adjustment and respond to any comments made by the Physician Payment Review Commission.

(iii) Provides that if the adjustment results in a reduction in the reasonable charge for a nonparticipating physician, the physician may not charge the beneficiary more than 125 percent of the adjusted prevailing charge. Any excess amounts must be refunded. The Secretary may impose sanctions in the case of violations.

(b) Payments for Cataract Surgery.—

Section 4527.—

(i) Places a limit on prevailing charges for cataract surgery with intraocular lens implantation equal to 110% of the prevailing charge recognized for such surgery without the lens implant. In determining the reasonable charge for cataract surgery anesthesia, the Secretary may not recognize more than 4 base units (as used for purposes of determining anesthesia payments on the date of enactment).

(ii) Specifies that non-participating physicians may not charge more than 125% of the adjusted prevailing charge for cataract surgery with lens implantation and cataract surgery anesthesia. If the physician charges more he/she shall refund any excess amounts. The Secretary may impose sanctions in the case of physicians who knowingly and willfully impose excess charges or fail to make refunds.

Effective date.—(a) Effective on enactment. (b) Applies to services furnished on or after January 1, 1987.

Senate amendment

(a) Reasonable charge limits/inherent reasonableness.—

Section 10232.—

(i) No provision.

(ii) Specifies that the inherent reasonableness authority must be applied through regulation for physicians and prohibits carriers from acting independently, without the issuance of regulations.

(iii) Requires the Secretary, by October 1, 1987 to review the inherent reasonableness of reasonable charges for each of the 10 most costly procedures paid for under part B, determined on the basis of aggregate annual payments. The Secretary may review additional procedures.

Section 4526.—

(i) Specifies the factors to consider in determining the inherent reasonableness of charges. The identified factors would include cases where: prevailing charges are significantly different from those in comparable localities; Medicare and Medicaid are the main sources of payment; the marketplace for the service is not truly competitive because of the limited number of physicians performing the service; there have been increases in charges not explained by inflation; charges do not reflect changing technology or reductions in acquisition or production costs, or the prevailing charges are substantially higher than payments made by other purchasers. Regional differences in fees are to be taken into account unless there is substantial economic justification for a uniform national fee or payment limit.

(ii) Similar provision. Specifies that the proposed notice must explain factors and data taken into consideration and evaluate the impact on the accessibility of and beneficiary liability for the service. Provides that the Commission shall comment on the proposed rule during the public comment period.

(iii) No provision.

(b) *Payments for cataract surgery.—No provision.*

Effective date.—Applies to final regulations promulgated after July 1, 1986; required review by Secretary effective on enactment.

Conference agreement

(a) *Reasonable charge limits inherent reasonableness.*—The conference agreement includes the Senate provision and the House provision in Section 4526 with modifications as follows:

Under the inherent reasonableness authority, the Secretary would be authorized to establish a payment level for a physician service based on considerations other than the actual, customary, or prevailing charge for the service. A departure from the standard methodology would be appropriate under a number of circumstances, including the following: (i) the prevailing charge for a service in a particular locality is significantly in excess of, or below, the prevailing charge for the same service in other comparable localities taking into account the relative costs of furnishing the service; (ii) medicare and medicaid are the sole or primary sources of payment for the service; (iii) the marketplace for the service is not truly competitive; (iv) there have been increases in charges for a service that cannot be explained by inflation or technology; (v) the charges do not reflect changing technology, increased facility with that technology, or reductions in acquisition or production costs; (vi) the prevailing charge for a service under this part are substantially higher or lower than the payments made for the service by other purchasers in the same locality.

The Secretary would be authorized to make an adjustment in payment is such adjustment is justified on the basis of an appropriate comparison of resource costs or charges. An adjustment may be based on one of the following types of comparison: (i) a comparison between charges and resource costs for related procedures; (ii) a comparison between charges and resource costs for the procedure over a period of time; (iii) a comparison between charges for a procedure in different geographic areas; and (iv) a comparison between charges and allowed payments for a procedure under this part and by other payers. The term “resource costs” includes factors such as the time required to provide a procedure (including pre-procedure evaluation and post-procedure follow-up), the complexity of the procedure, the training required to perform the procedure, and the risk involved in the procedure.

Adjustments based on comparisons of charges for a procedure in different geographic areas may be made only if the Secretary determines that the prevailing charge allowed in a locality is out of line with prevailing charges allowed in other localities after accounting for differences in practice costs. The Secretary would not be authorized to establish a uniform fee or payment limit under this provision unless the Secretary determines that there is substantial economic justification for a uniform fee or a uniform payment limit. Such justification would have to be explained in a proposed and final notice.

In determining whether to adjust payments rates, the Secretary would be required to consider the potential impacts on quality, access, and beneficiary liability of the adjustment, including the

likely effects on assignment rates, reasonable charge reductions on unassigned claims, and participation rates of physicians.

The Secretary would be required to consult with representatives of physicians likely to be affected at an appropriate stage in the process. The Secretary would also be required to publish a proposed notice: (i) specifying the charge or methodology proposed to be established, (ii) explaining the factors and data on which the proposal is based and (iii) explaining the potential impacts on quality, access, and beneficiary liability. After publication of the proposed notice, the Secretary would be required to allow 60 days for public comment. The Physician Payment Review Commission would be required to comment on the proposal, and the Secretary would be required to take into account the comments made by the Commission and by the public in making a final determination. The final notice shall explain the factors and data that the Secretary took into consideration in making a final determination and must include and respond to the comments made by the Commission.

If an adjustment is made that results in a reduction in the payments allowed for a service, a special limit on actual charges for nonparticipating physicians would apply. The purpose of this special limit is to moderate beneficiary liability for charges in excess of the medicare approved charge. For the first year the reduction is in effect, the maximum allowable actual charge for the service equals 125% of the inherently reasonable charge level plus one-half of the difference between the physician's actual charge in the preceding period and 125% of the inherently reasonable charge level. In the second year, the special maximum allowable charge for the service equals 125% of the inherently reasonable charge level.

The Secretary is required to review payments under this section for 10 of the most costly procedures paid for under Part B. The secretary should have flexibility in choosing the procedures in terms of those for which modifications might be the most cost effective. If the Secretary determines that for one or more of such overpriced procedures that a payment adjustment cannot be made pursuant to this section, he shall report recommendations to Congress concerning appropriate statutory changes.

(b) Payments for cataract surgery.—The conference agreement includes the House provision with amendments. The maximum allowable prevailing charges for participating and nonparticipating physicians providing cataract surgery would be cut by 10% effective January 1, 1987. The maximum allowable prevailing charges would be cut by an additional 2% effective January 1, 1988. In no case could the reduced amount be lower than 75% of the weighted national average prevailing charge amounts. The Secretary would be required to issue in final form the proposed notice which was published on August 15, 1986 in the Federal Register which would require that carriers recognize no more than 4 base units for anesthesia services provided during cataract surgery.

By ratifying the regulations relating to payment limits for anesthesia services, the Congress does not intend that the Secretary be restricted in his authority to subsequently revise these regulations.

Nonparticipating physicians providing cataract surgery services and cataract surgery anesthesia would be required to reduce their

actual charges for these services effective January 1, 1987 pursuant to the method described under paragraph (a).

23. END STAGE RENAL DISEASE PROGRAM AMENDMENTS (SECTIONS 10233, 4506, AND 4507 OF HOUSE BILL, SECTION 623 OF SENATE AMENDMENT)

Present law

The End-Stage Renal Disease Program (ESRD) provides coverage for the cost of routine maintenance dialysis for persons with chronic kidney (renal) failure.

(a) *Composite rate for dialysis treatment.*—The Secretary shall provide by regulation for a method of reimbursing facilities for routine maintenance dialysis care. Such method provides for the prospective determination of rates based on a single composite weighted formula which takes into account the mix of patients receiving dialysis services at home or in a facility and which reflects the relative costs of providing dialysis services in such settings. The Secretary may provide for exceptions to the prospective payment rates as may be warranted, such as for sole facilities located in isolated rural areas.

In regulations published on May 13, 1983 (effective August 1, 1983), the Secretary established a prospective reimbursement rate for dialysis facilities. The reimbursement rates are calculated on per-treatment base rates (adjusted for wage differences) of \$122.91 for independent facilities and \$126.76 for hospital-based facilities. On May 13, 1986, the Secretary published a proposed rule that would reduce the base rates to \$113.47 for independent facilities and \$117.89 for hospital-based facilities.

(b) *Payment for physician's services.*—Physicians are reimbursed for services related to routine maintenance dialysis care on the basis of a monthly capitation fee that encourages the use of home dialysis.

The regulations establishing the payment rates for physicians were based, in part, on the assertion that the physician could oversee the dialysis care of ten home patients in the same amount of time as seven facility patients, resulting in a facility to home physician treatment capability ratio of 1 to 1.4 in the determination of the composite rate. On March 19, 1986, the Secretary published a proposed rule, based on GAO study, that would change the facility to home physician treatment capability ratio to 1 to 3.9. On July 2, 1986, this change was published as a final rule, effective August 1, 1986. This change will result in an estimated reduction of physicians' average monthly capitation payments for dialysis care from \$187.88 to \$173.07.

(c) *Study of dialysis payment rates.*—No provision.

(d) *Coverage of immunosuppressive drugs.*—Medicare provides coverage for kidney and heart transplants, including organ procurement costs, hospitalization, surgical fees, and immunosuppressive drugs provided in the hospital or administered by a physician.

(e) *Reorganization of ESRD network areas.*—The Secretary shall establish renal disease network areas and such network organizations (including a coordinating council and medical review boards) for the purpose of assuring the effective and efficient administra-

tion of the ESRD program. The Secretary has established 32 network areas. Under COBRA, the Secretary may consolidate the number of network areas to not less than 14. The Secretary is proposing through regulations to reduce the number of network areas to 14 and to modify the current functions of the networks.

(f) *Patient representation on councils and medical review boards.*—At least one patient representative shall serve as a member of each network coordinating council and executive committee.

(g) *Responsibilities of network organizations.*—The network organizations are responsible for: encouraging use of appropriate treatment settings, developing criteria, standards and network goals with respect to quality and appropriateness of treatment, evaluating procedures by which facilities assess appropriateness of treatment, identifying facilities not cooperating in achieving network goals, and submitting to the Secretary by July 1 of each year an annual report.

(h) *Facility cooperation with networks.*—The Secretary may terminate or withhold certification of facilities that consistently fail to cooperate with network plans and goals.

(i) *Maximum use of vocational rehabilitation services.*—It is the intent of Congress that the maximum practical number of patients who are medically, socially, and psychologically suitable for home dialysis or transplantation should be so treated.

(j) *National end stage renal disease registry.*—The Secretary shall submit to Congress an annual report on the ESRD program.

(k) *Funding of ESRD network organizations.*—No provision.

(l) *Reuse of dialysis filters and other dialysis supplies.*—No provision.

House bill

(a) *Composite rate for dialysis treatment.*—

Section 10233.—Permits the Secretary to adjust the composite rates to dialysis facilities, but only if the base rate for dialysis in an independent facility is not less than \$117.50 per treatment and only if the base rate for hospital-based facilities is not less than \$121.50 per treatment. An application for a payment exception for sole facilities located in isolated rural areas shall be deemed approved unless the Secretary disapproves it by not later than 45 working days after the request for the exception is filed.

Section 4506.—Similar provision except that it adds pediatric dialysis facilities as a basis for payment exception requests, and applies 45 day deadline to all exception requests.

(b) *Payment for physicians' services.*—

Section 10233.—Requires the Secretary to implement the changes in physicians' monthly capitation payments for dialysis payments as published in the Federal Register on July 2, 1986.

Section 4506.—Provides that the Secretary shall establish a home to facility physician treatment capability ratio such that the average monthly capitation payment to physicians (based on a weighted average by State ESRD population) would be reduced to \$180.00. Such adjustment is to be made such that it would apply to services rendered on or after August 1, 1986.

(c) *Study of dialysis payment rates.*—

Sections 10233 and 4506.—The Secretary shall provide for a study to evaluate the effectiveness of reductions in payment rates for facility and physician dialysis services and report to Congress not later than January 1, 1988. The Secretary is required to request the National Academy of Sciences to submit an application to conduct the study. If the Academy does not submit an acceptable proposal, the Secretary may request other appropriate entities to submit applications to conduct the study.

(d) *Coverage of immunosuppressive drugs.*—

Section 10233.—No provision.

Section 4506.—Provides that immunosuppressive drugs furnished to a transplant patient within 1 year of the transplant would be a covered service under part B of Medicare.

(e) *Reorganization of ESRD network areas.*—

Sections 10233 and 4507.—Requires the Secretary to establish not less than 17 ESRD network areas, and to designate a network administrative organization that includes a network council of dialysis and transplant facilities in the area, and a medical review board. The Secretary shall develop standards, criteria and procedures for evaluating whether to enter into, continue or terminate an agreement with the network administrative organization. The Secretary may terminate such agreements only after applying such standards and finding that the organization has failed to perform its prescribed responsibilities. In the case of a termination, the Secretary may select a successor organization on the basis of competitive bidding. The Secretary shall designate the network areas not later than January 1, 1987. In first designating the network administrative organizations for the areas so established, the Secretary shall designate the current network organizations (or voluntary combinations of such organizations) unless such organizations do not meet the standards established.

(f) *Patient representation of councils and medical review boards.*—

Sections 10233 and 4507.—Requires at least one patient representative on each network council and each medical review board.

(g) *Responsibilities of network organizations.*—

Sections 10233 and 4507.—Amends the responsibilities of the network organizations to include in addition to current law functions: encouraging participation of patients, providers, and facilities in vocational rehabilitation programs, setting standards and criteria for such participation, reporting to the Secretary on facilities and providers not providing appropriate care, implementing a patient grievance process, conducting onsite review of facilities and providers, collecting and analyzing data to report to the Secretary, and providing data to assure maintenance of the National ESRD Registry.

(h) *Facility cooperation with networks.*—

Sections 10233 and 4507.—Adds failure to follow the recommendations of the medical review board as a basis for the Secretary to terminate or withhold certification.

(i) *Maximum use of vocational rehabilitation services.*—

Sections 10233 and 4507.—Amends current provision to include that the maximum number of patients who are suitable for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment.

(j) *National end stage renal disease registry.*—

Section 10233.—Requires the Secretary to establish a national end stage renal disease registry using data from networks, transplant centers and other sources that will permit: preparation of the Annual Report to Congress, analysis of the economic impact and medical efficacy of alternative treatment modalities, evaluation of the allocation of resources for treatment and research and measurement of patient mortality and morbidity rates and other indices of quality of care over time. The Secretary shall provide for the appointment of a professional advisory group and will report to Congress on the progress made in establishing such registry not later than January 1, 1987, and establish the registry by January 1, 1988.

Section 4507.—Similar provision.

(k) *Funding of ESRD network organizations.*—

Section 10233.—Requires the Secretary to reduce the composite rates paid to facilities by \$0.50 per treatment (adjusted for modalities of treatment other than hemodialysis) and to provide for payment of such amounts to the network organization for the area in which the treatment is rendered to provide for the administrative costs of the networks.

Section 4507.—Similar provision.

(l) *Reuse of dialysis filters and other dialysis supplies.*—

Sections 10233 and 4507.—Requires the Secretary to establish protocols on standards and conditions for the reuse of dialysis filters for those facilities and providers who voluntarily elect to reuse such filters. The Secretary shall study the appropriateness of establishing protocols for reuse of other dialysis supplies and, where appropriate, the Secretary may establish such protocols. The protocols established are to be incorporated into the requirements of participation for facilities. Failure to follow such protocols may result in denial of participation or denial of payment for services not in compliance with such protocols.

The Secretary shall establish the protocol on filter reuse not later than January 1, 1988 and shall report to Congress on the need for other such protocols by January 1, 1988.

Effective date.—Enactment except for the following:

(a) Payment provision applies to services rendered on or after October 1, 1986. Exception provision applies to exception applications filed on or after October 1, 1986.

(b) August 1, 1986, for section 4516.

(d) Applies to immunosuppressive drugs provided on or after October 1, 1986.

(e) (f), (g) and (h) No later than January 1, 1987.

(k) Applies to treatment furnished on or after January 1, 1987.

Senate amendment

(a) *Composite rate for dialysis treatment.*—Prohibits the Secretary from reducing the current prospective payment dialysis rates prior to October 1, 1986. The Secretary is required to reduce the prospective payment dialysis rates by \$1 for services rendered on or after October 1, 1986 and before October 1, 1988, and is prohibited from further reducing the rates during this period.

(b) *Payment for physicians' services.*—Same provision as Section 10233 of the House bill.

(c) *Study of dialysis payment rates.*—The Comptroller General shall conduct a study of facility payment rates for dialysis services and report to Congress not later than September 30, 1987.

(d) *Coverage of immunosuppressive drugs.*—No provision.

(e) *Reorganization of ESRD network areas.*—No provision.

(f) *Patient representation on councils and medical review board.*—No provision.

(g) *Responsibilities of network organizations.*—No provision.

(h) *Facility cooperation with network organizations.*—No provision.

(i) *Maximum use of vocational rehabilitation services.*—No provision.

(j) *National end stage renal disease registry.*—No provision.

(k) *Funding of ESRD network organizations.*—No provision.

(l) *Reuse of dialysis filters and other dialysis supplies.*—No provision.

Effective date.—Enactment.

Conference agreement

(a) *Composite rate for dialysis treatment.*—The conference agreement includes the Senate amendment with a modification requiring the Secretary to reduce the base rate for calculating the prospective payment by \$2 for services furnished on or after October 1, 1986. The Secretary must maintain that rate for two years and would be authorized to change the rate thereafter. The conference agreement includes section 4506 of the House bill's exceptions provision, with an amendment providing sixty, rather than forty-five, working days for the approval or disapproval requirement of exceptions requests.

(b) *Payment for physicians' services.*—The conference agreement does not include the House provision or Senate amendment. The Administration's changes in physicians' monthly capitation payments for dialysis payments as published in the Federal Register on July 2, 1986, remains effective as published.

(c) *Study of dialysis payment rates.*—The conference agreement includes the House provision.

(d) *Coverage of immunosuppressive drugs.*—The conference agreement includes the House provision.

(e) *Reorganization of ESRD network areas.*—The conference agreement includes the House provision with an amendment deleting the preference for existing networks in awarding competitive contracts. To allow for an orderly transition, the existing network organizations will remain in operation until thirty days after the new network organizations begin operation.

(f) *Patient representation on councils and medical review boards.*—The conference agreement includes the House provision.

(g) *Responsibilities of network organizations.*—The conference agreement includes the House provision.

(h) *Facility cooperation with networks.*—The conference agreement includes the House provision.

(i) *Maximum use of vocational rehabilitation services.*—The conference agreement includes the House provision.

(j) *National end stage renal disease registry.*—The conference agreement includes the House provision.

(k) *Funding of ESRD network organizations.*—The conference agreement includes the House provision, with amendments. The preference for existing networks is deleted. It is also clarified that the competitive bidding for the establishment of new networks includes price competition. In determining which applicant will be awarded the network contract, the Secretary may not weight the price of the bid by more than 20% and must weight the quality and scope factors by at least 80%. The conferees intend that the new funding mechanism is to cover the necessary costs of the existing networks until 30 days after the new networks begin operating.

(l) *Reuse of dialysis filters and other dialysis supplies.*—The conference agreement includes the House provision with an amendment. The Secretary shall impose standards and conditions for safe and effective dialyzer reuse and reprocessing, enforceable as a condition of medicare participation effective October 1, 1987. Beginning January 1, 1988, no reuse of blood lines, transducers, caps and other accessories shall be allowed in Medicare certified ESRD facilities until and unless standards and conditions for safe reuse and reprocessing of these devices and equipment are imposed as a condition of participation.

Effective dates.—The conference agreement includes the House provision, except the designation of the network areas is to be completed by May 1, 1987 and the new networks are to be established by July 1, 1987.

24. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PART B (SECTIONS 10234 AND 4531 OF HOUSE BILL)

Present law

(a) *Additional members for Physician Payment Review Commission.*—The Physician Payment Review Commission established by COBRA consists of 11 commissioners. The Commission was established to provide recommendations concerning physician reimbursements under part B. Commission members are appointed by the Director of the Office of Technology Assessment.

(b) *Effective date on voluntary disenrollment from Medicare.*—A beneficiary's coverage period under part B can be terminated by filing a notice that he or she no longer wishes to participate or by nonpayment of premiums. When a beneficiary files a notice to disenroll from part B, the effective date of the termination is the close of the calendar quarter following the calendar quarter in which the notice is filed; a termination for nonpayment of premiums takes effect with the end of a grace period (not more than 90 days).

(c) *Study on prospective payment of radiology, anesthesia, and pathology services to hospital inpatients.*—The Health Care Financing Administration conducts a variety of studies on reimbursement, coverage, eligibility, and management alternatives under Medicare.

House bill

(a) *Additional members for Physician Payment Review Commission.*—

Section 10234.—Expands the membership of the Physician Payments Review Commission by 2 members to 13. The Director of the Congressional Office of Technology Assessment shall appoint the two additional members of the Commission no later than 60 days after the date of the enactment of this Act, for terms of 3 years, except that the Director may provide initially for such terms as will ensure that (on a continuing basis) the terms of no more than five members expire in any 1 year.

Section 5431.—Similar provision.

(b) *Effective date on voluntary disenrollment from Medicare.*—

Section 10234.—Modifies the effective date of disenrollment from Medicare when a beneficiary files a notice to disenroll to the close of the calendar quarter in which the notice is filed.

Section 4531.—No provision.

(c) *Study on prospective payment of radiology, anesthesia, and pathology services to hospital inpatients.*—

Section 10234.—Requires the Secretary to study and report to the House Ways and Means Committee by April 1, 1987, concerning the implementation of a part B prospective payment system for radiology, anesthesia, and pathology services furnished to hospital inpatients. The report is required to include data, from a representative sample, showing, for discharges classified within each diagnosis-related group, the distribution of total reasonable charges and costs for each inpatient discharge for such services.

Section 4531.—No provision.

Effective date.—(a) enactment; (b) applies to notices filed on or after October 1, 1986; (c) enactment.

Senate amendment

No provision.

Conference agreement

(a) *Additional members for Physician Payment Review Commission.*—The conference agreement includes the House provision. The conferees intend that at least one of the members would represent a rural area.

(b) *Effective date on voluntary disenrollment from Medicare.*—The conference agreement includes the House provision of Section 10234 with an amendment specifying that the effective date is the first day of the second month following the month in which the beneficiary files the required notice.

(c) *Study on prospective payment of radiology, anesthesia and pathology services to hospital inpatients.*—The conference agreement includes the House provision of Section 10234 with an amendment to delay the reporting date of the study to July 1, 1987.

25. VISION CARE (SECTION 4521 OF HOUSE BILL)

Present law

Medicare pays for eye examinations furnished by a physician to a patient with a complaint or symptom of eye disease or injury. Medicare excludes payment for eyeglasses and eye examinations for the purposes of prescribing, fitting, or changing eyeglasses (except for prosthetic lenses for aphakic patients; that is, those without the natural lens of the eye.) Payment is also excluded for procedures performed to determine the refractive state of the eye. An optometrist who is legally authorized by the State to practice optometry is defined as a physician, but only with respect to services related to the treatment of aphakic patients.

House bill

Allows payment under Medicare for vision care services performed by optometrists, if the services are among those already covered by Medicare when furnished by a physician and if the optometrist is authorized by State law to provide the services.

Effective date.—Services furnished on or after April 1, 1987.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

26. OCCUPATIONAL THERAPY SERVICE (SECTION 4522 OF HOUSE BILL;
SECTION 625 OF SENATE AMENDMENT)*Present law*

Medically necessary occupational therapy services are covered under part A when provided as part of covered inpatient hospital services, skilled nursing facility services, home health services or hospice care. Part B coverage is limited to treatment in a hospital outpatient department, comprehensive outpatient rehabilitation facility, home health agency, or when provided incident to physicians' services.

House bill

(a) Services furnished in skilled nursing facilities and other providers.—Extends part B coverage of occupational therapy services to services provided in skilled nursing facilities (when part A coverage has been exhausted), in a clinic, rehabilitation agency, or public health agency or by others under arrangements with such entities. Reimbursement is on the basis of reasonable costs subject to the provision that the reasonable costs of services furnished under arrangements cannot exceed the amount that would be paid on a salary related basis.

(b) Services furnished in beneficiary's home and private offices.—Extends part B coverage to occupational therapy services furnished by an independently practicing therapist in a therapist's office or a beneficiary's home. The independently practicing therapist would be required to meet licensing and other standards prescribed by the

Secretary. Reimbursement is on the basis of 80 percent of reasonable charges, with no more than \$500 in incurred expenses eligible for coverage in a calendar year. A physician must certify the need for such services and a treatment plan must be established by a physician or by the qualified occupational therapist.

Effective date.—Applies to expenses incurred for outpatient occupational therapy services furnished on or after April 1, 1987.

Senate amendment

(a) *Services furnished in skilled nursing facilities and other providers.*—Identical provision.

(b) *Services furnished in beneficiary's home and private offices.*—Identical provision.

Effective date.—Applies to expenses incurred for outpatient occupational therapy services furnished on or after October 1, 1986.

Conference agreement

(a) *Services furnished in skilled nursing facilities and other providers.*—The conference agreement includes the Senate amendment with an amendment changing the effective date to July 1, 1987.

(b) *Services furnished in beneficiary's home and private office.*—The conference agreement includes the Senate amendment with an amendment changing the effective date to July 1, 1987.

27. COVERAGE OF SERVICES OF A PHYSICIAN ASSISTANT (SECTION 4523 OF HOUSE BILL)

Present law

Payments are made to a physician for services and supplies furnished incident to a physician's professional services. The services of nonphysicians are covered as incident to physicians' services and such services must be rendered under the physician's direct supervision.

House bill

(a) *Covered services.*—Authorizes coverage of the services of physicians' assistants furnished under the supervision of a physician in a hospital, skilled nursing facility, or as an assistant-at-surgery. The physician assistant must be legally authorized to perform such services in the State in which the services are performed. Services and supplies furnished incident to these services are covered if they would be covered when furnished incident to physicians' services.

(b) *Payment for services.*—The prevailing charge for a service furnished by a physician's assistant may not exceed 90% of the prevailing charge for the same service when furnished by a physician. Payment may only be made to the employer of the physician assistant when services are provided on the basis of assignment.

Effective date.—Services furnished on or after January 1, 1987.

Senate amendment

No provision.

Conference agreement

(a) *Covered services.*—The conference agreement includes the House provision with an amendment to add to the definition of covered physician assistant services those services provided by a physician assistant in an intermediate care facility.

(b) *Payment for services.*—The conference agreement includes the House provision with a modification. Physician assistant services are subject to a prevailing charge screen equal to 85% of the prevailing charge for comparable physicians services performed by nonspecialists when such services are performed in skilled nursing facilities or intermediate care facilities. The prevailing charge screen is to be equal to 75% of the nonspecialist physicians prevailing charge level when such services are performed in a hospital and 65% of the reasonable charge for a physician when acting as an assistant at surgery. The conference agreement requires physician assistants to accept assignment for all claims and imposes civil monetary penalties for violations.

The agreement requires the Secretary to submit a report to Congress by April 1, 1988 concerning appropriate adjustments to payments for physician assistant services to ensure that payments for such services approximate the cost of furnishing such services, including compensation costs and overhead costs, and costs of physician supervision attributable to employment of physicians' assistants. The Secretary, in making recommendations to the Congress, shall consider both the advisability of adjusting current rates or developing a fee-schedule.

The Secretary is authorized to reduce Medicare payment rates to the extent necessary to avoid double payments for such services. The Secretary is expected to require carriers to conduct utilization review of claims to avoid duplication of payment for physicians and physician assistant services.

28. PAYMENT FOR CLINICAL DIAGNOSTIC LABORATORY TESTS (SECTION 4528 OF HOUSE BILL)

Present law

Payment for clinical laboratory services are made on the basis of two fee schedules. One fee schedule is established for laboratory tests performed either in a physician's office or by an independent laboratory (including a hospital laboratory furnishing services to persons who are not patients of the hospital). A second schedule is established for hospital laboratory services provided to a hospital's outpatients.

For the period beginning July 1, 1984, the rates under both schedules were established on a regional, statewide, or carrier service area basis. The first fee schedule was set at 60 percent of the prevailing charge levels established for the fee screen year beginning July 1, 1984. The second fee schedule was set at 62 percent of the prevailing charge levels established for the fee screen year beginning July 1, 1984. The fee schedules are adjusted annually to reflect changes in the consumer price index for all urban consumers. Beginning July 1, 1986, the Secretary is required to establish payment ceilings for each test to be applied nationwide. Beginning July 1, 1988, the fee schedule for tests performed either in a physi-

cian's office or by an independent laboratory is to be established on a national basis. At the same time, payment for hospital laboratory services is slated to revert to cost-based reimbursement.

House bill

(a) *Treatment of hospital outpatient laboratories.*—Conforms fee schedule for hospital outpatient laboratories to that for independent laboratories by eliminating the 2 percent differential and by eliminating the January 1, 1988, sunset provision on the fee schedule for such laboratory services.

(b) *National fee schedule.*—Eliminates requirement for the national fee schedule. The Secretary is required to report to the Congress by April 1, 1988, on the advisability and feasibility of establishing a national fee schedule.

(c) *Payment for travel costs.*—Authorizes the Secretary to provide for and establish a fee to cover transportation and personnel expenses for trained personnel to travel to the location to collect the sample. Such fee may only be provided with respect to a beneficiary who is homebound or an inpatient in a facility other than a hospital.

(d) *State standards for directors of clinical laboratories.*—Specifies that clinical laboratories that meet State licensure laws regarding medical direction are qualified to receive payments under Medicare.

Effective date.—(a) applies to tests performed on or after January 1, 1987. (b) effective on enactment. (c) applies to samples collected on or after January 1, 1987. (d) effective January 1, 1987.

Senate amendment

No provision.

Conference agreement

(a) *Treatment of hospital outpatient laboratories.*—The conference agreement includes the House provision with an amendment. The 2 percent differential for hospital outpatient laboratories would be maintained for such laboratories if they are in a hospital which operates a 24 hour per day emergency room, and the laboratory is available to provide laboratory services for the emergency room 24 hours a day, seven days a week.

(b) *National fee schedule.*—The conference agreement includes the House provision with an amendment. Implementation of the national fee schedule would be postponed for two years, until January 1, 1990.

(c) *Payment for travel costs.*—The conference agreement includes the House provision.

(d) *State standards for directors of clinical laboratories.*—The conference agreement includes the House provision.

In addition, the conference agreement would extend the moratorium on the competitive bidding demonstration project until January 1, 1988. The conferees expect the Secretary to continue to work with the industry and the Comptroller General to determine whether there is an alternative method of utilizing competitive market forces in establishing payment levels under Medicare.

29. PAYMENT OF PARENTERAL AND ENTERAL NUTRITION SUPPLIES
(SECTION 4529 OF HOUSE BILL)

Present law

Reasonable charges for medical services, supplies and equipment that, in the judgment of the Secretary, do not vary substantially in quality from one supplier to another may not exceed the lowest charge levels at which such services, supplies and equipment are widely and consistently available, except to the extent and under circumstances specified by the Secretary. Regulations implementing this provision established such lowest charge levels at the 25th percentile of the charges submitted for the item or service in question.

Parenteral and enteral nutrition supplies and equipment are currently paid on the basis of reasonable charges.

House bill

Requires the Secretary to apply the lowest charge level provision to parenteral and enteral nutrition supplies.

Effective date.—Applies to supplies on or after January 1, 1987.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision with a modification. In establishing the "lowest charge level" for parenteral and enteral supplies, the Secretary would be required to base payments at the 25th percentile as currently set forth in regulations (42 CFR 405.511(c)). The conferees expect that all available charge data submitted by suppliers of such services would be used in calculating the lowest charge levels. The Secretary and carriers would therefore be prohibited from using "inherent reasonableness" in establishing the lowest charge level.

In addition, the conferees are concerned that some items (e.g. supply and administration kits) are billed on a partial month basis which may distort the charge data. The conferees expect the Secretary to ensure that the data used in establishing the lowest charge level for these items are accurate.

In comparing charges submitted for various items, the conferees expect the Secretary to compare like products which are of comparable quality and nutritional content rather than looking solely at the volume of nutrients or calorie content. In addition, the conferees expect that the Secretary would not group together products of dissimilar quality or function.

The conferees are concerned that current categories for reimbursing premixed parenteral solutions may be inappropriate. The conferees therefore expect the Secretary to establish new categories for premixed parenteral solutions based on the amount of proteins prescribed per day. The Secretary would be expected to calculate payment levels at the 25th percentile based on the charge data available for the new categories. To provide sufficient time to collect the data, the effective date for parenteral products would be October 1, 1987.

Between January 1, 1987 and October 1, 1987, the Secretary is to apply existing charge screens to these parenteral nutrients. However, rather than applying many different screens to the various states, the Secretary should apply uniform screens throughout the nation, or uniform screens throughout each of the two carrier areas.

It is the conferees' understanding that certain parenteral nutritional patients require special parenteral solutions such as renal failure solutions, hepatic failure solutions, or acute metabolic stress formulas. The Secretary would be expected to provide for separate categorization or appropriate exceptions to accommodate these patients and for other special circumstances.

The provision would be effective for parenteral nutrients October 1, 1987, and for all other services and supplies on January 1, 1987.

30. PAYMENT FOR OXYGEN THERAPY SERVICES (SECTION 4530 OF HOUSE BILL)

Present law

Oxygen therapy services provided in the home are reimbursed on a reasonable charge basis under part B of Medicare.

Payments for equipment are determined separately from payments for consumable oxygen. Total payments for consumable oxygen are determined by the amount of oxygen actually supplied.

House bill

Requires the Secretary to establish monthly capitation fee schedules on a regional, statewide, or carrier service area basis for oxygen therapy services under part B. Payment shall be made on the basis of the number of units of oxygen prescribed by physicians, subject to verification by laboratory data or other means deemed appropriate by the Secretary.

No payment may be made for services prescribed by a physician if the physician has significant ownership or financial interest in the entity supplying the oxygen therapy services, except with respect to sole suppliers as determined by the Secretary.

The Secretary will provide for prompt payment of claims for oxygen therapy services (clean claims to be paid within 22 calendar days), or the carrier will pay interest on the amount payable. The carriers are to be reimbursed for their interest expense from amounts made available for Federal administrative expenses under part B.

The Secretary shall establish the monthly capitation fee schedules based on 100 percent of the reasonable charge level for oxygen therapy services (excluding purchase or rental of equipment) for such services furnished in the region, State, or area for the 12 month period ending June 30, 1986. The fee schedules are to be adjusted annually, effective January 1 (beginning in 1987), by the percentage change in the Consumer Price Index for All Urban Consumers, subject to adjustments for technological changes and other factors as determined by the Secretary.

The Secretary shall provide for a percentage increase in the fee schedule amounts for oxygen therapy services provided through a portable device. The Secretary shall also provide for a minimum

monthly amount to assure the availability of such therapy for individuals consuming small amounts of oxygen.

Program payment amounts are to be 80 percent of the amount determined under the monthly prospective fee schedule. In general, payment would only be made on the basis of assignment.

Effective date.—Applies to oxygen therapy services furnished on or after January 1, 1987.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

31. CHANGING MEDICARE APPEAL RIGHTS (SECTION 4532 OF HOUSE BILL)

Present law

Beneficiaries dissatisfied with a carrier's disposition of a part B claim are entitled to a review by the carrier. A fair hearing by the carrier is then available if the amount in controversy is \$100 or more. The law does not provide for any further administrative appeal or judicial review for a part B claim.

House bill

Provides that beneficiaries may obtain an administrative law judge hearing if the amount in controversy is \$500 or more and judicial review if the amount in controversy is \$1,000 or more. In determining the amount in controversy, the Secretary under regulations must allow two or more claims to be aggregated if the claims involve the delivery of similar or related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals. Carrier hearings are retained for amounts in controversy between \$100 and \$500.

Specifies that national coverage determinations made pursuant to section 1862(a)(1) of the Act are not subject to review by an administrative law judge but are subject to judicial review.

Effective date.—Applies to items and services furnished on or after January 1, 1987.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision with amendments regarding the scope of judicial review and the form of relief that a court may order.

Coverage determinations of national applicability could not be overturned solely on the grounds that they were not issued in accordance with the notice and comment procedures in the Administrative Procedure Act, as amended. The process used by the Secretary in making such determinations, including the role of the National Center for Health Services Research and Health Care Technology Assessment, is designed to assure consultation with the sci-

entific and medical community and the general public. If that process is adhered to, the further procedure of publishing proposed and final regulations in the Federal Register does not seem essential.

The court could, however, review coverage determinations to determine whether the Secretary arrived at the result in an arbitrary manner or without an adequate basis. If the court invalidated a coverage determination on this basis, it would not substitute a revised coverage determination but, instead, would provide the Secretary a reasonable opportunity to supplement the record and substantiate or revise the coverage determination. If the court, on review of the supplemented record, concluded that the Secretary had still failed to substantiate the determination, the court could then enter an appropriate order.

The amendment also limits the judiciary in reviewing payment methodologies established by the Secretary. Methodologies established by regulation or policy instruction could not be declared invalid if the regulation was promulgated or the instruction issued prior to January 1, 1981. Policies would otherwise be reviewable.

32. ALZHEIMER'S DISEASE DEMONSTRATION PROJECTS (SECTION 4533 OF HOUSE BILL)

Present law

Medicare beneficiaries with Alzheimer's disease or related disorders are covered for acute medical care services they might need. However, many of the home and community-based services which these persons require in order to remain in their homes are not covered by Medicare.

House bill

Requires the Secretary of HHS to conduct at least 5 demonstration projects to determine the effectiveness, cost, and impact of providing comprehensive services to Medicare beneficiaries who are victims of Alzheimer's disease or related disorders. Services provided under the demonstration projects must be designed to meet the specific needs of Alzheimer's disease patients and may include case management, home and community-based services, mental health services, outpatient drug therapy, respite care and other supportive services and counseling for family, adult day care services and other inhome services. Each demonstration project would be conducted over a period of 3 years and at sites chosen so as to be geographically diverse and located in States with a high proportion of Medicare beneficiaries and in areas readily accessible to a significant number of Medicare beneficiaries.

Requires that projects provide each Medicare beneficiary with a comprehensive medical and mental status evaluation upon entering the project and at discharge. Also requires that projects be conducted by entities which either directly or by contract are able to provide these evaluations and additional services covered. Projects also would be required to involve community outreach efforts at each site to enroll the maximum number of Medicare beneficiaries in each project.

Requires the Secretary to waive compliance with Medicare requirements to the extent and for the period he finds necessary for the projects.

Requires the Secretary to provide for an evaluation of the projects and to submit to Congress two reports: a preliminary report during the third year of the projects and a final report upon completion that includes recommendations for appropriate legislative changes.

Specifies that expenditures not exceed \$40 million for the projects and \$2 million for the evaluation and be made from the Federal Supplementary Medical Insurance Trust Fund.

Effective date.—Enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision with an amendment permitting the Secretary to conduct additional demonstration projects, up to a total of 10, within the appropriation of \$40 million over 3 years. The Secretary could undertake the additional projects by reducing the number of beneficiaries participating in these demonstrations from 500 to approximately 250.

The conferees intend the services covered under this demonstration to supplement current Medicare acute care benefits. These additional benefits are not to replace, reduce, restrict, or otherwise substitute for existing benefits provided through Medicare which the beneficiaries might need. These demonstration projects are to be funded from the Medicare Part B trust fund, without being charged against the monies appropriated for the research activities of the Health Care Financing Administration.

In addition, the conference agreement includes a modification to the preventive health services demonstration program as added by COBRA. The agreement would clarify that the \$4 million funding limitation specified in COBRA applies only to the administrative cost of designing and conducting the demonstration and the accompanying evaluation. The funding limitation would be increased by \$1.9 million.

The provision would also specify that at least one of the five sites chosen for the demonstration must serve a rural area.

33. AMBULATORY SURGERY (SECTION 624 OF SENATE AMENDMENT)

Present law

Payment for facility services.—Medicare may pay for ambulatory surgical procedures performed in three different settings:

Ambulatory surgical center (ASC).—The Omnibus Reconciliation Act of 1980 (P.L. 96-499) authorized payments for facility services furnished in connection with ambulatory surgical procedures specified by the Secretary. Payments to ASCs are made on the basis of prospectively set rates known as the "standard overhead amount." On August 5, 1982, HHS issued final regulations and an accompanying notice identifying four groups of surgical procedures and the payment amount for

each group. The payment amounts and the list of procedures has not been updated. The rates do not include payments for physicians' services, prosthetic devices, or laboratory services. No beneficiary cost-sharing is required.

Hospital outpatient department.—Medicare payments for ambulatory surgery performed in a hospital outpatient department are made on the basis of reasonable costs. The standard Part B beneficiary cost-sharing is required.

Physician's office.—P.L. 96-499 also authorized payments to be made to physicians for the use of their office facilities when covered ambulatory surgical procedures were performed there. However, the legislation has not been implemented because adequate utilization and quality control peer review, which is required by law, is not available for office-based surgery.

Payment for physicians' services.—When surgery is performed in any of these three settings, Medicare reimburses 100 percent of the physician's reasonable charge, provided the physician agrees to accept assignment.

House bill

No provision.

Senate amendment

(a) *Payment rates.*—Provides that payments to hospital outpatient departments for procedures approved for ASCs, would be the lesser of the outpatient department's cost or the payment rate for the same surgical procedure in an ASC in the same geographic area.

When the payment rate is based on the ASC payment rate, the outpatient department would receive additional payments for the cost of the services of certified nurse anesthetists (for cost reporting periods beginning before October 1, 1987) and for the direct costs of medical education.

The Secretary is required to review and update the ASC payment rates not later than July 1, 1987, and annually thereafter, and to review and update the list of approved procedures not less than annually.

(b) *Facility services definition.*—Specifies that "facility services" for which payment is made includes all "medical and other health services" furnished in connection with the procedure except the services of physicians.

(c) *PRO review.*—Requires Peer Review Organization contracts to provide for review of all ambulatory surgical procedures (or, at the Secretary's discretion, a sample of selected procedures) performed in ASCs and hospital outpatient departments.

(d) *Coinurance and deductible to apply without regard to setting of ambulatory surgery.*—Repeals current law provisions waiving coinsurance and deductible requirements for ASC services.

(e) *Development of prospective payment methodology for outpatient hospital services.*—Requires the Secretary to develop groupings of pre- and postoperative services that are related to surgical services performed in a hospital outpatient department and then develop a model prospective reimbursement system that may be used for reimbursing hospitals under part B. The Secretary is re-

quired to report to Congress on the groupings and the model reimbursement system not later than January 1, 1991.

(f) *Study of educational activities.*—Requires the Secretary to conduct a study on educational activities in hospital outpatient departments. The Secretary shall report the results to Congress not later than 2 years after enactment.

Effective date.—The payment provisions in (a) apply to cost reporting periods beginning on or after July 1, 1987. (b) and (d) apply to services furnished after June 30, 1987. (c) applies to contracts entered into or renewed after January 1, 1987. All other provisions are effective on enactment.

Conference agreement

(a) *Payment rates.*—The conference agreement includes the Senate amendment with modification. The conferees anticipate that the payment mechanism established under this section will be a transitional step, and the conference agreement requires the development and implementation of a fully prospective payment system for ambulatory surgery procedures provided in hospital outpatient departments (OPDs) by October 1, 1989.

Under the conference agreement, a new payment methodology for facility services provided by hospital OPDs in connection with ambulatory surgery would be established effective for hospital cost reporting periods beginning on or after October 1, 1987. Payments would be based on a comparison between the amount that would be paid to a hospital OPD under Section 1833(a)(2)(B) and a blended amount based on the amount that would be paid to an OPD under Section 1833(a)(2)(B) and the payment that would be made to a free-standing ambulatory surgery center (ASC) under Section 1833(i)(2)(A) (as amended by paragraph d). Under Section 1833(a)(2)(B), services provided by an OPD are paid at the lesser of the reasonable cost for the service or the hospital's customary charge for the service, less 20% of the hospital's reasonable charge, as provided under Section 1866(a)(2)(ii), not to exceed 80% of reasonable cost. Under Section 1833(i)(2)(A), ASCs are paid 80% of a "standard overhead amount" which is intended to reflect costs incurred by ASCs.

During a cost reporting period, aggregate payment to a hospital outpatient department (OPD) for facility services for ambulatory surgery procedures would be the lesser of: (i) the aggregate amount that would be paid to an OPD under Section 1833(a)(2)(B) of the Social Security Act of (ii) an aggregate amount based on a blend of the OPD payment under Section 1833(a)(2)(B) and the ASC payment under Section 1933(i)(2)(A). For cost reporting years beginning during FY 1988, the blend is 75% OPD payment and 25% ASC rate. For cost reporting years beginning during FY 1989 (and in subsequent years), the blend is 50% OPD payment and 50% ASC rate.

Medical and other health services, other than facility services, which are provided by a hospital OPD in connection with an ambulatory surgery procedure which are otherwise covered under medicare would continue to be reimbursed on the basis of Section 1833(a)(2)(B). While the Secretary will have flexibility in defining the term "facility services" for purposes of this provision, it is an-

ticipated that the term will be defined in a manner that is comparable to the definition of the term "ASC facility service" that appears at 42 CFR 416.61.

The conference agreement does not include the Senate amendment concerning nurse anesthetist and direct medical education costs because, under the conference agreement, these provisions are not needed to ensure payment of these costs. The services of a nurse anesthetist are not included in the current definition of "ASC facility services," and it is anticipated that such services would not be included within the term "facility services" for purposes of paying hospital OPDs. Accordingly, no "pass-through" is required for the costs of hospital-employed nurse anesthetists, and these costs will continue to be reimbursed on a reasonable cost basis. In addition, no "pass-through" is required for direct medical education costs because of the payment methodology established for these costs under Section 1886(h) of the Social Security Act.

(b) *Facility service definition.*—The conference agreement does not include the Senate amendment, but does require that all services (other than physician services) provided by an OPD be billed through the hospital. Separate billing for such items or services by other suppliers would be prohibited and violations would be subject to civil monetary penalties.

(c) *PRO review.*—The conference agreement includes the Senate amendment with technical clarifications regarding the requirement that PROs review some or all of the ambulatory surgery services provided by hospital OPDs and ASCs. Under the agreement, the Secretary would have discretion to review a sample of such procedures.

(d) *Coinsurance and deductible to apply without regard to setting of ambulatory surgery.*—The conference agreement includes the Senate amendment.

(e) *Development of prospective payment methodology for outpatient hospital services.*—The conference agreement includes the Senate amendment with the following modifications. The Secretary would be required to submit an interim report to Congress by April 1, 1988 concerning development of a fully prospective payment system for ambulatory surgery. The following issues are to be addressed in the interim report: (i) whether payment for hospitals should be based on hospital costs in providing ambulatory services, or the ASC payment rate, or a blend of the two; and (ii) recommendations for developing and implementing an all-inclusive payment for ambulatory surgery encompassing payment for facility services and all medical and other health services commonly furnished in connection with an ambulatory surgical procedure other than the physicians' service. The Secretary would be required to submit a final report to Congress no later than April 1, 1989 with recommendations concerning implementation of a fully prospective payment mechanism for ambulatory surgery services by October 1, 1989. The Secretary would also be required to develop a model system for prospective payment of OPD services other than ambulatory surgical procedures and submit a report to Congress concerning the model system by January 1, 1991.

(f) *Study of educational activities.*—The conference agreement does not include the Senate amendment.

III. UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATION (PRO) PROVISIONS

1. PEER REVIEW ORGANIZATIONS (SECTION 10241 OF HOUSE BILL; SECTIONS 631, 632, AND 633 OF SENATE AMENDMENT)

Present law

(a) *PRO Review of Hospital Denial Notices.*—By regulation, hospitals are authorized to make determinations that further inpatient care is no longer medically necessary. If the attending physician concurs with this determination, the hospital may serve the beneficiary with a discharge notice and may begin to charge for continued stay beginning with the third day after serving the notice. The beneficiary may appeal the discharge notice to a peer review organization (PRO). If the PRO reverses the hospital's determination, the hospital may not bill for continued inpatient stay. The PRO is required to decide the appeal within 3 working days after receipt of the appeal. Under current policy, a beneficiary may incur financial liability for several days of continued stay before receiving notice of the PRO's decision in the event of an adverse decision.

(b) *PRO Review of Inpatient Hospital Services and Early Readmission Cases.*—PROs review the necessity and quality of hospital services provided to beneficiaries.

(i) To initiate the review process, a PRO must receive data concerning the number and type of hospital discharges from hospitals in the PROs services area. This information is provided to PROs by Medicare fiscal intermediaries. There is no statutory provision regarding timely provision of data to PROs.

(ii) Under PRO contracts for 1986–88, PROs will be required to review all readmissions to a hospital where the readmission occurs within 15 days after initial discharge.

(c) *Requiring PRO Review of Quality of Care.*—PROs are required to review a sample of the professional activities of health care practitioners and providers for purposes of determining whether the services provided were medically necessary and meet professionally recognized standards of care. COBRA required PROs to review services provided by health maintenance organizations (HMOs) and competitive medical plans (CMPs) effective January 1, 1987. A required level of effort for PRO review of HMO and CMP services is not specified.

(d) *Requiring consumer representation on PRO boards.*—No Provision.

(e) *Improve peer review responsiveness to beneficiary complaints.*—No provision.

(f) *Sharing of information by PROs.*—PRO confidential information is subject to protection.

(g) *Funding of PRO activities.*—The costs of PRO review are funded by transfer of funds from the Federal Hospital Insurance Trust Fund. Under current law, the aggregate amount to be paid to all PROs during a year must be no less than the aggregate amount expended during FY 1986 on PRO reviews adjusted for inflation.

*House bill**(a) PRO review of hospital denial notices.—*

(i) Provides that if a hospital determines and the physician agrees that the patient no longer requires inpatient care, the hospital may provide that patient with a coverage denial notice.

(ii) Provides that if a hospital has determined but the physician does not agree that the patient no longer requires inpatient care, the hospital may request the PRO to review the validity of the hospital's determination.

(iii) Provides that if a patient has received a denial notice and requests the PRO to review the determination, the PRO shall conduct a review of the validity of the hospital's determination and shall provide notice to the patient, hospital, and attending physician. Such review is to be provided regardless of whether or not the hospital will charge for continued care or whether or not the patient will be liable for payment for continued care.

(iv) Provides that if the patient requests a review while still an inpatient and not later than noon of the first working day after receipt of the hospital denial notice, the hospital must provide the PRO with the records required to review the determination by the close of business of such day, and the PRO must provide notice by not later than one full working day after it has received the request and the records.

(v) Provides that if the patient has made a timely request, and the patient did not know and could not reasonably have been expected to know that continued inpatient stay was not necessary, the hospital may not charge the patient before noon of the day after receipt of the PRO's decision.

(vi) Requires PRO's in conducting reviews to solicit the views of the patient.

(b) PRO review of inpatient hospital services and early readmission cases.—

(i) Requires the Secretary to provide that PROs receive each month either from hospitals or through fiscal intermediaries, data necessary to initiate the review process on a timely basis.

(ii) Requires PROs to perform early readmission reviews to determine if the previous inpatient hospital services and post-hospital services met professionally recognized standards of health care. The reviews may be done on a sample basis if the PRO and Secretary determine it to be appropriate. Any early readmission case is defined as one where a readmission occurs within 31 days of discharge.

(c) Requiring PRO review of quality of care.—

(i) Requires each PRO to provide that a reasonable proportion of its activities are involved with reviewing the quality of services and that a reasonable allocation of such activities is made the different cases and settings (including inpatient hospital care, post-acute care settings, ambulatory settings, health maintenance organizations, and competitive medical plans). In establishing the allocation, the PRO shall consider: (1) whether there is reason to believe that there is need for review of par-

ticular cases or settings because of previous problems; (2) the cost and potential yield from reviews; and (3) the availability and adequacy of alternative quality review and assurance mechanisms.

(ii) Requires each PRO contract to provide for review of inpatient and outpatient services provided by HMOs and CMPs to determine whether the quality of services meets professionally recognized standards of health care, including whether appropriate health services have not been provided or have been provided in inappropriate settings. The level of effort expended by PROs under the requirement shall be equivalent on a per beneficiary basis, to that expended on utilization and quality reviews with respect to Medicare beneficiaries not enrolled in an HMO or CMP.

(iii) Requires the Secretary, in consultation with appropriate experts, to identify methods that would be available to assist PROs in identifying those cases which are more likely than others to be associated with substandard quality.

(d) *Requiring consumer representation on PRO boards.*—Requires at least one consumer representative on PRO boards.

(e) *Improve peer review responsiveness to beneficiary complaints.*—

(i) Requires PRO's to conduct appropriate reviews of all written complaints by beneficiaries about the quality of services not meeting professionally recognized standards. The PRO is required to inform the beneficiary of its conclusions and final disposition.

(ii) Before the PRO concludes that the quality of care is substandard, it must provide the practitioner or person concerned with reasonable notice and opportunity for discussion.

(f) *Sharing of information by PROs.*—

(i) Provides that confidential information, relating to a specific case or possible pattern of substandard care, obtained by PROs could be shared, upon request, with a State licensing or certification agency or with a national accreditation body, but only to the extent that such information is required by such agency or body to carry out official functions.

(ii) Provides that confidential information obtained by PROs could be shared with State ombudsmen and State protection and advocacy officials, but only to the extent that such information is related to the quality of services furnished and only if the PRO determines that the information may reflect a failure in a substantial number of cases or a gross and flagrant failure in one or more instances to provide services of a quality which meets professionally recognized standards of health care. Further the information must be needed in connection with official duties.

(g) *Funding of additional PRO activities.*—Requires hospitals, skilled nursing facilities and home health agencies to maintain an agreement with the appropriate PRO with respect to review of services provided by hospitals, skilled nursing facilities or home health agencies (other than inpatient hospital services) and with respect to review of beneficiary complaints regarding quality. The activities are to be considered a cost of providing services and are to be paid directly by the Secretary to the PRO. Payments are to

be transferred in appropriate amounts from the part A and part B trust funds and shall not be less in the aggregate than the amount determined by the Secretary to be sufficient to cover the costs of specified review activities. Similar provisions apply with respect to HMOs and CMPs.

Effective date.—(a) Applies to denial notices furnished by hospitals to individuals on or after the first day of the first month that begins more than 30 days after enactment except that (a)(v) effective on enactment. (b)(i) Requires the Secretary to implement amendment not later than 6 months after the date of enactment. (b)(ii) Applies to contracts entered into or renewed on or after January 1, 1987. (c)(i) and (c)(ii) apply to contracts as of January 1, 1987 except that provision requiring equivalent PRO effort for HMOs and CMPs applies to review activities conducted on or after January 1, 1988. (c)(iii) Effective on enactment. (d) Applies to contracts entered into or renewed on or after January 1, 1987. (e) Applies to complaints received on or after the first day of the first month that begins more than 9 months after the date of enactment. (f) Applies to requests for data and information made on and after the end of the sixth month period beginning on the date of enactment. (g) Amendments apply to provider agreements as of October 1, 1987 and risk-sharing contracts with HMOs and CMPs as of January 1, 1987.

Senate amendment

(a) PRO review of hospital denial notices.—

(i) Identical provision.

(ii) Identical provision.

(iii) Similar provision. Specifies that the provision applies to requests made by a person who is still an inpatient. The PRO notice must be given to the patient within two calendar days after receipt of request. No PRO notice to hospital or attending physician is required.

(iv) No provision.

(v) Provides that if an inpatient makes a request for PRO review within 1 day after the date he or she receives the denial notice, the hospital may not charge the patient for services furnished before the fourth day after receipt of the denial notice.

(vi) Identical provision.

(b) PRO review of inpatient hospital services and early readmission cases.—

(i) Requires the Secretary to provide that fiscal intermediaries are to furnish the necessary data. If the Secretary determines that a fiscal intermediary is unable to furnish the information on a timely basis, he may require the hospital to do so.

(ii) Identical provision.

(c) Requiring PRO review of quality of care.—

(i) Similar provision respecting allocation of activities except specifies that the allocation among cases and settings is to be based on instances where potential problems of quality have been identified. Does not include provision relating to items the PRO must consider.

(ii) No provision.

(iii) Identical provision.

(d) *Requiring consumer representation on PRO boards.*—No provision.

(e) *Improve Peer Review Responsiveness to beneficiary complaints.*—

(i) Similar provision. Specifies that the complaint and the name of the complainant shall be treated as confidential. The PRO is required to inform the individual that the organization has received the complaint and will take appropriate action.

(ii) No provision.

(f) *Sharing of information by PROs.*—

(i) Similar provision. Specifies information is related to a specific provider or practitioner. Provides that information can only be shared to the extent: (1) it relates to the quality of care provided; (2) the PRO determines it may reflect a failure in a substantial number of cases or a gross and flagrant failure in one or more instances to provide services meeting professionally recognized standards of health care; and (3) it is needed by the body in carrying out official duties.

(ii) No provision.

(g) *Funding of additional PRO activities.*—No provision.

Effective date.—(a) Applies to denial notices furnished by hospitals to individuals on and after the first day of the first month that begins more than 30 days after enactment. (b)(i) Requires the Secretary to implement the amendment not later than six months after enactment. (b)(ii) Applies to contracts entered into or renewed after January 1, 1987. (c)(i) Applies to contracts entered into or renewed on or after January 1, 1987. (c)(iii) Effective on enactment. (e) Applies to complaints received on or after the first day of the first month that begins at least 9 months after the date of enactment. (f) Applies to data and information requests made on and after the end of the six-month period beginning on the date of enactment.

Conference agreement

(a) *PRO review of hospital denial notices.*—The conference agreement includes the House provision.

(b) *PRO review of inpatient hospital services and early readmission cases.*—The conference agreement includes the Senate amendment with a modification excluding review of services provided by physicians in an office setting from the scope of review for early readmission cases until January 1, 1989.

(c) *Requiring PRO review of quality of care.*—The conference agreement includes the House provision with the following amendments. The requirement that PROs allocate a reasonable proportion of their review activities to reviewing different cases and settings would be delayed for two years as it pertains to review of services provided by physicians in an office setting.

The requirement of PRO review of HMOs and CMPs is amended by delaying the deadline for initiation of PRO review of HMOs and CMPs from January 1, 1987 as provided in the House bill to April 1 of that year. In at least 25 states the Secretary must contract for review of HMO and CMP services with the organization which has a contract to conduct review of inpatient and outpatient services pursuant to Section 1154 of the Social Security Act. The Secretary has the authority under the provision to competitively bid the con-

tract for quality review of HOM and CMP services in the remaining twenty-five states on a state-by-state basis. No more than 50% of the total number of medicare beneficiaries enrolled in HOMs or CMPs, as of the date of the competition, can be included in the twenty-five states which are subject to competitive bidding. To qualify for the competitively bid contracts, quality review organizations must satisfy the requirements of Sections 1152 and 1153(b)(3) of the Act.

The Secretary would be required to provide data (and associated data processing support) to at least 12 PROs to enable each PRO to review and analyze small area variations in the utilization of hospital and other health services within the PROs service area. The PROs would use the small area variation information in establishing priorities for review activities and in conducting educational programs for community physicians.

(d) Requiring consumer representation on PRO boards.—The conference agreement includes the House provision.

(e) Improve peer review responsiveness to beneficiary complaints.—The conference agreement includes the Senate amendment with the following modifications. If the PRO makes a final determination with respect to whether the services which are the subject of a complaint did or did not meet professionally recognized standards of care, the PRO would be required to inform the beneficiary involved (or the beneficiary's representative) of any final action taken. Before the PRO concludes that the services involved did not meet professionally recognized standards of care, the PRO would be required to provide the practitioner (or other person concerned) with reasonable notice and opportunity for discussion.

(f) Sharing of information by PROs.—The conference agreement includes the House provision with respect to sharing of information with State licensing and certification agencies and with national accreditation bodies. The agreement does not include the House provision with respect to sharing of information with State ombudsmen and State protection and advocacy officials. The conferees emphasize the responsibility of PROs to protect the confidentiality of patient information.

(g) Funding of PRO activities.—The conference agreement includes the House provision.

VI. ACCESS TO HEALTH INSURANCE COVERAGE PROVISIONS

1. INCENTIVES FOR THE ESTABLISHMENT OF STATE HEALTH INSURANCE POOLS (SECTION 10251 OF HOUSE BILL)

Present law

States are not required to establish health insurance pools for the purpose of offering health insurance to people that are otherwise unable to purchase health insurance. However, 10 States have enacted laws establishing comprehensive health insurance associations. These associations are independent nonprofit corporations governed by a board and administered by an insurance carrier selected by the board.

The 10 States base employer participation in such pools on whether the employer maintains a health insurance plan, rather

than requiring all employers to participate whether or not they maintain a health insurance plan. Accordingly, only health insurance carriers who provide health insurance plans governed by State law are required to participate in such pools. Because the Employment Retirement Income Security Act (ERISA) preempts State law, employer-based, self-funded health plans have been exempted from any State mandate to participate in such pools.

The existing State pools are financed primarily by beneficiary premiums. To the extent that the premium revenues are insufficient, the losses of the pool are shared among the health insurance carriers underwriting health insurance in the State. However, ERISA preempts State laws relating to employee benefit plans, except for laws relating to the regulation of insurance. Self-funded employer-based plans have been found to be exempt from State laws under the ERISA preemption. Accordingly, the self-funded plans do not share in the losses of the existing pools.

House bill

(a) *General rule.*—Amends Chapter 41 of the Internal Revenue Code of 1954 to provide for a tax on the wages paid by large employers that are not members of qualified State health insurance pools and that employ individuals to perform services in a State that has established such a pool. The tax is equal to 5 percent of the wages paid by the employer during the taxable year for services performed in the State by the employees.

(b) *Large employer defined.*—A large employer is defined as an employer who, on each of some 20 days (each day being in different calendar weeks), employed 20 or more individuals for some portion of the day. The term does not include the United States, any State or political subdivision, any possession of the United States, or any agency or instrumentality of any of the foregoing (including the Postal Service and Postal Rate Commission), except that the term shall include any nonappropriated fund instrumentality of the United States.

(c) *Exception for certain churches and associated organizations.*—Exempts church organizations from participation in the State health insurance pools which fund procedures that are contrary to their religious tenets.

(d) *Qualified health insurance pool defined.*—A qualified health insurance pool is defined as any organization which: (1) is a non-profit organization established pursuant to and regulated by State law; (2) permits any large employer doing business in the State to be a participating member; and (3) makes available (without regard to health status) to all residents of the State not entitled to Medicare, levels of health insurance typical of large employer group coverage. Any such level of insurance must limit the annual out-of-pocket expenses to specified limits and may not establish lifetime benefit limits for any individual less than \$500,000. The coverage may provide for a choice of deductibles but not to exceed \$1,000 per covered individual. The plan may exclude coverage for preexisting conditions for a period not to exceed 6 months. The coverage must include the purchase and repair of durable medical equipment.

A qualified pool may charge a premium rate expected to be self-supporting, but such premium rate may not exceed 150 percent of

average premium rates for individual standard risks in the State for comparable coverage.

State health insurance pools may deny coverage for some or all services or other costs relating to abortions.

The organization shall assess losses of the pool equitably among all participating members.

The term "State" includes the District of Columbia and the Commonwealth of Puerto Rico.

(e) Establishment of qualified State health insurance pools.—Congress intends that each State shall establish a qualified health insurance pool by not later than January 1, 1988, or, if later, the end of the first regular State legislative session that begins after the enactment of this Act.

Effective date.—Applies to taxable years beginning on or after January 1, 1988.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

2. COBRA TECHNICAL AMENDMENTS RELATING TO CONTINUATION OF EMPLOYER-BASED HEALTH INSURANCE COVERAGE (SECTION 10252 OF HOUSE BILL)

Present law

COBRA amended the Internal Revenue code to prohibit deductions for employer contributions to group health plans maintained by private employers that do not provide continuation coverage to certain specified employees and their spouses and dependents who would otherwise lose their group health insurance coverage as a result of specified qualifying events. Qualifying events include: death of the covered employee; termination or reduction of hours of the covered employee's employment; divorce or legal separation of the covered employee from the employee's spouse; the covered employee becoming entitled to Medicare; or a dependent child ceasing to be a dependent child under the plan.

COBRA also made comparable amendments to the Employment Retirement Income Security Act and the Public Health Service Act.

(a) Modification of coverage.—All qualified beneficiaries who would otherwise lose coverage as a result of a qualifying event are entitled to elect continuation coverage. The continuation coverage must be identical to the coverage provided under the plan to similarly situated beneficiaries for whom a qualifying event has not occurred.

(b) Maximum period of continuation coverage.—The continuation coverage period must extend from the period beginning on the date of the qualifying event and end not earlier than 18 months after loss of coverage due to termination or reduction in working hours and 36 months in the case of other qualifying events.

(c) *Grace period for payment of premiums.*—The plan may require payment of a premium. No coverage need be provided under the plan if the beneficiary fails to make timely premium payments.

(d) *Election by beneficiaries.*—Each qualified beneficiary may elect continuation coverage. If the qualifying beneficiary is the covered employee (in the case of separation from service or a reduction of hours) or the spouse of the covered employee, the election is deemed to include election on behalf of any other qualified beneficiary who would otherwise lose coverage.

(e) *Notice requirement.*—The employer of any employee covered under a group health plan must notify the plan administrator within 30 days of the qualifying event in the case of the death of the employee, separation from service or reduction of hours of the employee, or the commencement of entitlement to Medicare benefits. In the case of other qualifying events, the covered employee or qualified beneficiary is responsible for notifying the plan administrator that a qualifying event has occurred. However, no time limit is specified in such events.

House bill

(a) *Modification of coverage.*—Amends the Internal Revenue Code to provide that if coverage is modified under the plan for similarly situated beneficiaries, such coverage shall be modified for all qualified beneficiaries.

(b) *Maximum period of continuation coverage.*—Amends the Internal Revenue Code to provide that in the case of a qualified beneficiary with respect to whom more than one qualifying event has occurred, the maximum period of coverage may be extended, but in no event may the coverage exceed a 36 month period (other than the period applicable to bankruptcies as described in section 10253 of the House bill; see item XX).

(c) *Grace period for payment of premiums.*—Amends the Internal Revenue Code to provide that the grace period for making timely payments is the longer of 30 days, the period the plan allows employees, or the period the insurance company allows the plan or employer, whichever the case may be.

(d) *Election by beneficiaries.*—Amends the Internal Revenue Code to clarify that each qualified beneficiary is entitled to make a separate election with respect to continuation coverage and among the types of such coverage available under the plan.

(e) *Notice requirement.*—Amends the Internal Revenue Code to provide that in the case of qualifying events for which the coverage employee or qualified beneficiary is responsible for notifying the plan administrator, such notice must be made within 60 days of the qualifying event.

Effective date.—Effective as if the amendments had been included in COBRA.

Senate Amendment

No provision.

Conference agreement

(a) *Modification of coverage.*—The conference agreement does not include the House provision.

(b) *Maximum period of continuation coverage.*—The conference agreement does not include the House provision.

(c) *Grace period for payment of premiums.*—The conference agreement does not include the House provision.

(d) *Election by beneficiaries.*—The conference agreement does not include the House provision.

(e) *Notice requirement.*—The conference agreement does not include the House provision.

3. CONTINUATION COVERAGE FOR RETIREES IN CASES OF BANKRUPTCIES (SECTION 10253 OF HOUSE BILL)

Present law

COBRA amended the Internal Revenue Code to prohibit deductions for employer contributions to group health plans maintained by private employers that do not provide continuation coverage to certain specified employees and their spouses and dependents who would otherwise lose coverage as a result of specified qualifying events.

COBRA also made comparable amendments to the Employment Retirement Income Security Act and the Public Health Service Act.

(a) *Loss of coverage of retiree through bankruptcy.*—The reduction of hours of the covered employee's employment; divorce or legal separation of the covered employee from the employee's spouse; the covered employee becoming entitled to Medicare; or dependent child ceasing to be a dependent child under the plan.

(b) *Period of continuation coverage.*—The continuation coverage period must extend from the period beginning on the date of the qualifying event and ending not earlier than 18 months after loss of coverage due to termination or reduction in working hours and 36 months in the case of other qualifying events. Continuation coverage may be terminated on the date on which the qualified beneficiary becomes entitled to Medicare.

(c) *Definition of qualified beneficiary in reorganization cases.*—A qualified beneficiary is defined as the covered employee of a group health plan (in the case when the qualifying event is the termination or reduction in hours of the employee) and any other individual who, on the day before the qualifying event, was a beneficiary under the plan as the spouse or dependent child of the employee.

House bill

(a) *Loss of coverage of retiree through bankruptcy.*—Amends the Internal Revenue Code to provide that the filing of a Title XI bankruptcy proceeding, commencing on or after July 1, 1986, is considered a qualifying event for continuation coverage with respect to the employer from whose employment the covered employee retired at any time, if such an event resulted in the substantial elimination of coverage for specified qualified beneficiaries within 1 year before or after the filing of the bankruptcy.

(b) *Period of continuation coverage.*—Amends the Internal Revenue Code to provide that the filing of a Title XI bankruptcy proceeding on or after July 1, 1986, which results in retirees' substantially losing health insurance coverage is a qualifying event, in

which case, the maximum period of continuation coverage is life for the retiree or the retiree's widow. After the death of the covered retiree, the maximum period of continuation coverage is 36 months for the surviving spouse and dependent children. In the case of a Title XI bankruptcy as a qualifying event, entitlement to Medicare benefits does not terminate the period of entitlement to continuation coverage.

(c) *Definition of qualified beneficiary in reorganization cases.*—Amends the Internal Revenue Code to provide that in the case of a Title XI bankruptcy as a qualifying event, the term qualified beneficiary includes a covered employee who had retired on or before the date of substantial elimination of coverage, and any other individual who, on the day before such qualifying event, is a beneficiary under the plan as the spouse or dependent child of the employee or as the surviving spouse of the employee.

Effective date.—In general, the amendments are effective as if they had been included in section 10001 of COBRA. Notwithstanding this effective date and section 10001 of COBRA, the amendments made by this section and section 10001 of COBRA shall apply in plan years ending during the 12 month period beginning July 1, 1986, but only with respect to a qualifying event of Title XI bankruptcy, and the qualifying event of death of the covered employee occurring after a Title XI bankruptcy. The section defining Title XI bankruptcy as the qualifying event applies to covered employees who retired before, on, or after the date of enactment.

Senate amendment

No provision.

Conference agreement

(a) *Loss of Coverage of Retiree Through Bankruptcy.*—The conference agreement includes the House provision with an amendment making a conforming amendment to Title I of ERISA. Because the continued access to private health insurance provision contained in COBRA, which this provision expands, amended both the Internal Revenue Code and ERISA, the conferees believe that an ERISA conforming amendment is appropriate. The conferees wish to clarify that upon the filing for Title XI bankruptcy retirees who have had their health benefits terminated or substantially reduced within one year of the filing for bankruptcy by the employer are entitled to buy the health coverage they had prior to the termination or substantial reduction in their health benefits.

(b) *Period of Continuation Coverage.*—The conference agreement includes the House provision with an amendment to include a Title 1 ERISA conforming amendment.

(c) *Definition of Qualified Beneficiary in Reorganization Cases.*—The conference agreement includes the House provision with an amendment to include a Title 1 ERISA conforming amendment.

V. REVENUE PROVISIONS

1. EXTEND MEDICARE COVERAGE AND HOSPITAL INSURANCE TAX TO STATE AND LOCAL GOVERNMENT EMPLOYEES

Present law

In the Consolidated Omnibus Budget Reconciliation Act (COBRA), P.L. 99-272, Medicare coverage and the corresponding hospital insurance payroll tax were extended on a mandatory basis to State and local government employees hired after March 31, 1986. COBRA also authorized States to elect, by voluntary agreement with HHS, to extend Medicare coverage to State and local government employees hired prior to April 1, 1986.

For Medicare-covered employees, the hospital insurance tax rate for 1986 is 1.45 percent on the employer and 1.45 percent on the employee, applicable to wages up to \$42,000 (Code secs. 3101, 3111, and 3121(a)).

House bill

No provision.

Senate amendment

The Senate amendment extends Medicare coverage on a mandatory basis to employees of State and local governments who are not otherwise covered for Medicare under present law. These employees and their employers will become liable for the hospital insurance portion of the FICA tax, and the employees will earn credit toward Medicare eligibility based on their covered earnings. (The optional Medicare coverage provision enacted in COBRA is terminated.)

Under the Senate amendment, the collection of the hospital insurance tax with respect to newly covered employees is to be carried out in the same manner as was provided in COBRA with respect to employees hired after March 31, 1986.

The Senate amendment is effective for services performed after April 30, 1987.

Conference agreement

The conference agreement does not include the Senate amendment.

2. DEPOSITS OF SOCIAL SECURITY CONTRIBUTIONS BY STATE AND LOCAL GOVERNMENT EMPLOYERS

Present law

A State that enters into a voluntary agreement with HHS to provide social security coverage for its employees and employees of its political subdivisions must collect and deposit the employer and employee social security tax payments on behalf of both the State and local entities. The local entities first pay over the social security taxes to the State, which must verify and consolidate the payments. The State then deposits these amounts, plus the appropriate tax payments with respect to its own employees, with the Federal Government on a twice-a-month deposit schedule.

Private employers must make payroll tax payments under a schedule that links the frequency of deposits to the amount of taxes withheld. Large employers may make deposits as frequently as eight times a month, while small employers may make deposits only once every three months. These rules applicable to private employers for depositing payroll taxes also apply to State and local governments for depositing Federal income taxes withheld from their employees.

Under present law, late deposits by State governments are subject to an interest charge at the rate of six percent per year. Private-sector employers pay an interest rate, adjusted semiannually, that is based on the prime interest rate charged by major commercial banks.

House bill

The House bill removes from State governments the intermediary role of collecting social security taxes from local governments, and relieves State governments from liability for verifying and depositing such taxes.

The House bill places State and local government employers under the same schedule for frequency of deposits as applies under present law to private-sector employers (and to deposits of Federal income taxes withheld by State and local government employers). Under the House bill, State and local governments are subject to the same interest charge and penalties for late deposits as apply to private-sector employers.

These provisions are effective for payments of social security taxes with respect to wages paid after December 31, 1986.

Senate amendment

The Senate amendment is the same as the House bill.

Conference agreement

The conference agreement follows the House bill and the Senate amendment.

3. TELEPHONE EXCISE TAX

Present law

Tax rate.—A three-percent excise tax is imposed on local and toll telephone service and teletypewriter service. The tax is scheduled to expire with respect to telephone bills first rendered after December 31, 1987 (Code Sec. 4251).

Exemptions.—Exemptions from the tax are provided for private communications systems, installation services, certain calls from coin-operated telephones, news services (except local services), international organizations, the American Red Cross, servicemen in combat zones, nonprofit hospitals and educational organizations, and State and local governments.

House bill

Extension of tax.—The House bill extends the three-percent tax for two years, through December 31, 1989.

Study of exemptions.—The House bill requires the Treasury Department to study the effects of the exemption for private telecommunications systems and other specific exemptions from the telephone excise tax. The Treasury is to report on the study to the Congress before January 1, 1988. The report is to include revenue effects of all present-law telephone excise tax exemptions and descriptions of types of persons benefiting from such exemptions.

Senate amendment

Extension of tax.—No provision.

Study of exemptions.—No provision.

Conference agreement

Extension of tax.—The conference agreement does not include the House bill provision.

Study of exemptions.—The conference agreement follows the House bill, with modifications that (1) in conducting the study, the Treasury Department is to consult with the Commerce Department and the Federal Communications Commission, (2) the study is to include methods by which the tax could be extended to private communications services users, and (3) the report on the study is to be submitted to the Congress no later than June 30, 1987.

4. EXTENSION OF PORTION OF FEDERAL UNEMPLOYMENT TAX (FUTA) DUE TO EXPIRE AFTER 1987

Present law

Under present law, the gross FUTA tax rate of 6.2 percent of the first \$7,000 in wages paid to an employee consists of a permanent component of 6.0 percent and a temporary component of 0.2 percent. (The net FUTA tax is 0.8 percent after taking into account the 5.4 percent credit for State unemployment taxes.) The funds generated by the temporary portion of the tax are used to repay advances made from general revenues to the Extended Unemployment Compensation Account. These advances have been utilized to pay for the Federal Supplemental Benefit program and the Federal share of the permanent extended benefit program.

The temporary 0.2-percent tax component is scheduled to expire at the beginning of the first year following the year in which the advances from general revenues are repaid (Code sec. 3301(1)). Current economic projections indicate that the advances will be fully repaid in mid-1987. As a result, for the year beginning January 1, 1988, the FUTA tax rate will be six percent (.6 percent after taking into account the 5.4 percent credit for State unemployment taxes).

House bill

The House bill provides that the temporary FUTA tax component of 0.2 percent will remain in effect for 1988 and 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

5. ACCELERATED COLLECTION OF CERTAIN EXCISE TAXES

Present law

Excise taxes on alcohol and tobacco products are paid semi-monthly, with payments being due the following number of days after each semimonthly period:

	<i>Days</i>
(a) domestically produced and bulk imported distilled spirits	30
(b) bottled imported distilled spirits	15
(c) beer and wine	15
(d) tobacco	25

In certain cases, payment of these excise taxes must be by means of electronic transfer of funds.

House bill

Under the House bill, payments of the excise taxes on tobacco, wine, and beer are due 14 days after the semimonthly period during which the products are removed from bonded premises. If the regular payment date falls on a Saturday, Sunday, or legal holiday, payment is due on the last preceding business day. The present-law rules requiring electronic transfer of funds in certain cases are retained.

This provision applies to taxable products removed during semi-monthly periods ending on or after December 31, 1986. Under a special rule, tobacco excise taxes for the semimonthly period ending on December 14, 1986, will be due on January 14, 1986 (rather than January 10, 1986).

Senate amendment

The Senate amendment is the same as the House bill except that (1) no change is made to the present-law payment date for the excise taxes on wine and beer and (2) payments of the excise taxes on distilled spirits are due 14 days after the semimonthly period during which products are removed from bonded premises. (Bottled imported distilled spirits are taxed on removal from customs custody.)

The Senate amendment applies to taxes paid after September 30, 1986, for semimonthly periods ending on or after that date. Under a special rule, tobacco excise taxes for the semimonthly period ending on September 15, 1986, will be due on October 14, 1986.

Conference agreement

Under the conference agreement, the excise taxes on (a) domestically produced and bulk imported distilled spirits, (b) bottled imported distilled spirits, (c) beer and wine, and (d) tobacco products are due 14 days after the semimonthly period when the taxable event occurs (14 days after entry into the customs territory of the United States in the case of certain imported products). If the regu-

lar payment date falls on a Saturday, Sunday, or legal holiday, payment is due on the last preceding business day.

As under present law, the taxable event generally is removal from a bonded factory, distillery, winery, or brewery in the case of domestically produced taxable products and certain bulk imported products (i.e., distilled spirits). As stated above, the taxable event for other imported products is entry into the customs territory of the United States. A further exception is provided in the case of an entry pursuant to which taxable products are transferred directly to a customs' bonded warehouse ("CBW"). (A foreign trade zone is treated as a CBW for this purpose.) In such a case, the taxable event is removal from the first such CBW into which the products are placed upon entry into the United States. This rule does not apply, however, to any article so removed which is shown to the satisfaction of the Secretary to be destined for export. Finally, for taxable products brought into the United States from Puerto Rico, tax is due 14 days after the products are brought into the U.S.

The conference agreement retains the present-law requirements for payment of these taxes by electronic transfer of funds.

Effective date.—These provisions apply to products removed in semimonthly periods ending on or after December 31, 1986, and to products entered into the customs territory (including entry into a CBW) of the United States (or otherwise brought into the U.S.) after December 15, 1986.

Special rules are provided consolidating payments for the semimonthly periods ending on December 15, 1986, and December 31, 1986, in the case of distilled spirits and tobacco products that now receive more than 15 days after removal for payment of tax.

The Consolidated Omnibus Budget Reconciliation Act of 1986 imposed a manufacturers excise tax on smokeless tobacco, effective for taxable products removed from the factory after June 30, 1986. However, in June 1985, the Treasury Department incorrectly notified manufacturers of smokeless tobacco that the tax did not apply to products held at the factory on July 1, 1986, in a condition ready for sale to consumers. The conference agreement amends the effective date of the tax on smokeless tobacco to exempt otherwise taxable products held at the factory on July 1, 1986, in a condition ready for sale to ultimate consumers.

6. INCREASES IN CERTAIN TAX PENALTIES

A. PENALTY FOR FAILURE TO DEPOSIT TAXES

Present law

Employers and certain other taxpayers are required to make periodic deposits of various taxes (such as social security taxes or income taxes withheld from employees) prior to the close of the taxable year. Taxpayers who fail to comply with these deposit requirements may be subject to a penalty of five percent of any underdeposit not deposited on or before the prescribed date, unless it is shown that the failure is due to reasonable cause and not due to willful neglect (Code sec. 6656).

House bill

Under the House bill, the penalty for failure to comply with these deposit requirements is increased from five percent to 10 percent of the amount of any underdeposit. The provision is effective with respect to deposits required to be made (whether by the Code or by regulations) after the date of enactment of the bill.

Senate amendment

The Senate amendment is the same as the House bill, except that the Senate amendment applies to penalties assessed after the date of enactment of the bill.

Conference agreement

The conference agreement follows the Senate amendment.

**B. PENALTIES FOR SUBSTANTIAL UNDERSTATEMENT OF TAX LIABILITY
AND FOR NEGLIGENCE**

Present law

Substantial understatement.—If a taxpayer substantially understates income tax liability for a taxable year, the taxpayer must pay an addition to tax equal to 10 percent of the underpayment of tax attributable to the understatement (sec. 6661). An understatement is substantial if it exceeds the greater of 10 percent of the tax required to be shown on the tax return or \$5,000 (\$10,000 in the case of most corporations). (Taxpayers subject to the penalty include individuals, corporations, and entities liable for the unrelated business income tax.) The penalty generally does not apply (except with respect to certain tax shelter items) to the extent the taxpayer (1) had substantial authority for the taxpayer's treatment of the item on the return, or (2) adequately disclosed the relevant facts on the return.

Negligence.—If any portion of an underpayment of tax is due to negligence or intentional disregard of rules or regulations (but without intent to defraud), a penalty of five percent of the entire underpayment is imposed (sec. 6653(a)).

House bill

Substantial understatement.—The addition to tax for a substantial understatement of tax liability is increased to 25 percent, effective for returns the due date of which is after December 31, 1986.

Negligence.—No provision.

Senate amendment

Substantial understatement and negligence.—If either the negligence or substantial understatement penalties (or both) apply, then the aggregate of these penalties must be at least 25 percent of the underpayment of tax. This provision is effective for penalties assessed after the date of enactment.

Conference agreement

Substantial understatement.—The conference agreement follows the House bill, effective for penalties assessed after the date of enactment.

Negligence.—The conference agreement follows the House bill (i.e., no change is made to the negligence penalty).

7. TAX TREATMENT OF CONRAIL PUBLIC SALE

Present law

In general, the purchase of the stock in corporation has no effect on the corporation's tax attributes (e.g., net operating loss carryovers, earnings and profits, and asset basis).

House bill

Under the House bill, the sale of Conrail's stock will be treated as an asset sale. Conrail will be treated as a new corporation that purchased the assets after the public sale. Thus, the aggregate basis for Conrail's assets will be adjusted to reflect the stock purchase price (plus liabilities and other relevant items). Similarly, no NOL or other carryovers from periods before the public sale will be available for use in post-sale periods.

In addition, no amount will be included in the gross income of Conrail by reason of the cancellation of any obligation or preferred stock of Conrail. Also, the House bill provides any post-closing payments for back wages must be capitalized. Finally, certain ESOP provisions are waived.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, with a modification providing that accounts receivable and materials and supplies will be treated as cash equivalents for purposes of applying the temporary regulations under section 338.

8. DENIAL OF TAX BENEFITS WITH RESPECT TO ACTIVITIES IN CERTAIN FOREIGN COUNTRIES

Present law

Foreign tax credit.—A credit against U.S. income tax is available for foreign income, war profits, and excess profits taxes paid to a foreign country or a U.S. possession. The amount of the foreign tax credit may be reduced, however, in certain circumstances. For example, a taxpayer that participates in or cooperates with an international boycott is denied a foreign tax credit for taxes paid on income derived within the countries associated with the boycott.

Deferral.—U.S. owners of a foreign corporation generally may defer U.S. tax on the corporation's income until the income is repatriated. However, this deferral of U.S. tax does not apply to certain kinds of income earned by U.S.-controlled foreign corporations, including income derived within countries associated with an international boycott in which the taxpayer participates or with which the taxpayer cooperates.

House bill

Foreign tax credit.—No provision.

Deferral.—No provision.

Senate amendment

Foreign tax credit.—The Senate amendment denies a foreign tax credit for taxes paid on income attributable to activities of the taxpayer conducted in a foreign country (1) that has been designated by the Secretary of State (pursuant to sec. 6(j) of the Export Administration Act) as a country that repeatedly provides support for acts of international terrorism, (2) with which the United States does not have diplomatic relations, or (3) the government of which the United States does not recognize (with certain exceptions). Income from one of these countries is subject to a separate foreign tax credit limitation, so that taxes from other countries cannot offset the U.S. tax on that income. The amendment provides regulatory authority for look-through rules to trace income (and taxes) from one of these countries through various entities.

Deferral.—The Senate amendment currently taxes U.S. shareholders of a controlled foreign corporation on the corporation's income attributable to activities conducted in a foreign country described in the preceding paragraph. The amendment provides regulatory authority for look-through rules to trace income from one of these countries through various entities.

Effective date.—The Senate amendment is effective on January 1, 1987.

Conference agreement

The conference agreement follows the Senate amendment. The conference agreement makes it clear that foreign taxes that are not creditable under this provision are deductible. In the case of dividends from foreign corporations that are attributable to earnings from activities conducted in one of the foreign countries subject to the agreement, the income of a U.S. recipient is the amount of the dividend net of foreign taxes (not grossed up by foreign taxes paid).

The conference agreement applies to income attributable to activities that occur after 1986 (and to taxes imposed on income earned after 1986). For example, in the case of a taxpayer with a fiscal year beginning October 1, income earned from January 1, 1987, to September 30, 1987 will be subject to the agreement, as will taxes (whenever paid) imposed on the income earned during that nine-month period.

9. OLDER AMERICANS PENSION BENEFITS

Present law

Age discrimination in Employment Act of 1967

Under present law, the Age Discrimination in Employment Act of 1967 (ADEA), as amended, makes it unlawful for employers to fail or refuse to hire or to discharge any individual (who is at least age 40 but less than age 70), or otherwise discriminate against such individual with respect to that individual's compensation, terms, conditions, or privileges of employment because of that individual's age.

Employers subject to ADEA include (1) any person engaged in an industry affecting commerce who has 20 or more employees (including agents of such persons), (2) a State, political subdivision of a State, or an agency of a State or political subdivision, and (3) any interstate agency. The United States, or a corporation wholly owned by the Government of the United States, is not considered an employer for purposes of ADEA. The Act does not apply to an employer who observes the terms of a bona fide employee benefit plan (such as a retirement, pension, or insurance plan) which is not a subterfuge to evade the purposes of the Act (sec. 4(f)(2)).

ERISA and the code

Employment benefit plans.—Under present law, benefits provided under employee benefit plans (including employer-maintained pension plans) are subject to certain requirements under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (the Code). ERISA and the Code impose certain minimum standards relating to minimum participation, vesting, and benefit accruals with respect to pension plans established or maintained by an employer engaged in commerce or in any industry or activity affecting commerce, or by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce, or by both. The minimum participation, vesting, and benefit accrual standards of ERISA and the Code do not apply to certain pension plans, such as governmental plans, certain church plans, and certain plans maintained only for executives.

If an employer-maintained pension plan satisfies the requirements of the Code, then contributions to the trust are deductible by the employer when made, trust earnings are not currently taxed, and contributions to the trust on behalf of an employee are not includible in the employee's income until distributed from the plan.

Exclusion from participation.—Under ERISA and the Code, a pension plan may not exclude an employee from plan participation merely because of the employee's age. However, a defined benefit pension plan and a target benefit plan may exclude an employee who is within five years of normal retirement age under the plan when the employee is first hired. Such employees are taken into account, even though otherwise excludable, in determining whether the plan satisfies minimum coverage requirements.

Benefit accruals.—Present law specifies certain requirements with respect to the rate at which benefits are accrued (i.e., earned) under a pension plan. These benefit accrual rules generally prevent the backloading of benefit accruals by specifying a minimum rate of benefit accrual for each year of plan participation.

A defined benefit pension plan is not required, under ERISA or the Code, to provide for benefit accruals for individuals who continue to work after the normal retirement age under the plan. In addition, under the suspension of benefit rules, benefits payable under a defined benefit plan are not required to be adjusted if an employee's benefit payments do not commence at normal retirement age. Plans that do not comply with the suspension of benefit rules are required to provide benefits that are actuarially equivalent to the benefit payable at the normal retirement age.

Commencement of benefits.—Under present law, benefit payments are required to commence to an employee not later than the sixtieth day after the latest of the close of the plan year in which (1) the employee attains the earlier of age 65 or the normal retirement age under the plan, (2) the tenth anniversary of the year in which the employee commenced participation in the plan, or (3) the employee separates from service with the employer. Therefore, present law permits a pension plan to provide that benefits are not payable until an employee separates from service. If a payment is delayed, however, the benefits paid at the time of separation from service are to be actuarially increased to take into account the employee's age at retirement unless the plan has adopted a suspension of benefits provision.

Suspension of benefits.—Under present law, a pension plan may provide for the suspension of benefit payments when a retired employee is reemployed by the same employer or certain affiliated employers in the case of a single-employer plan. In the case of a multiemployer plan, a plan may provide for the suspension of benefit payments when a retired employee is reemployed in the same industry, in the same craft, and in the same geographic area covered by the plan.

Benefits not paid by a plan during a period of reemployment are permanently forfeited, rather than merely suspended. Present law provides that a pension plan (other than a multiemployer plan) may provide for such a forfeiture if (1) the employee has at least 40 hours of service a month with the employer maintaining the plan, (2) the plan provides proper notice to the employee of the suspension, and (3) certain other requirements are satisfied. Similar requirements apply to multiemployer plans.

If the requirements for suspension of benefits are not met (or if the plan does not provide for a suspension of benefits), the plan may still delay the payment of benefits until the employee who has reached normal retirement age separates from service. However, in this case, section 411 of the Code and Revenue Ruling 81-140 require that, if payment is delayed, the benefits paid at the later date (i.e., actual separation from service) must be actuarially increased to take into account the employee's age at retirement. This increase is required to avoid a prohibited forfeiture of benefits.

House bill

No provision.

Senate amendment

The Senate amendment amends ADEA, ERISA, and the Code to require a plan to provide for benefit accruals and contributions with respect to an employee's years of plan participation after normal retirement age. Under the Senate amendment, a defined benefit plan may not provide that an employee's benefit accrual or contribution is suspended or the rate of an employee's benefit accrual or contribution is reduced solely because of the employee's age before the employee accrues the maximum normal retirement benefit under the plan.

The provision requiring that benefit accruals may not be suspended or reduced does not apply if a defined benefit pension plan

provides that an employee's retirement benefit is actuarially increased to reflect the payment of benefits after the attainment of normal retirement age.

A defined benefit pension plan is not treated as failing to satisfy the benefit accrual requirements merely because the plan (1) excludes an employee from plan participation if the employee is hired within five years before normal retirement age under the plan, or (2) imposes a limit on the benefits that the plan provides or on the number of years of service or plan participation taken into account in calculating an employee's benefit under the plan. In addition, a target benefit plan may exclude an employee from plan participation if the employee is hired within five years before normal retirement age under the plan.

A defined contribution plan satisfies the benefit accrual requirements in the plan provides that employer contributions (or forfeitures) allocated to an employee's account are not suspended or reduced on account of the employee's age. In addition, a defined contribution or target benefit plan may provide a limitation on the amounts allocated to an employee's account or on the number of years for which amounts are allocated to an employee's account.

The Senate amendment provides special rules in the case of a plan that provided (on the date of enactment) for the distribution or commencement of distribution of the entire interest of an employee under the plan on or after attainment of normal retirement age without regard to whether the employee has separated from service with the employer. Under this special rule, a plan amendment to postpone the date of commencement of benefits under the plan, which is adopted within the 12-month period following the date on which the provisions of the Senate amendment become applicable to the plan, is not to be treated as violating the rule that previously accrued benefits may not be retroactively reduced.

In the case of an integrated plan, the Senate amendment provides that the plan is not to be considered discriminatory merely because, in the case of an employee who has attained normal retirement age under the plan, the plan provides for a rate of benefit accrual or allocations to an employee's account (including retirement benefits created under State or Federal law) that does not exceed the rate of benefit accrual or allocations under the plan in the case of an employee who has not attained normal retirement age under the plan.

Effective date.—Under the Senate amendment, the provision is effective with respect to employees who are employed after December 31, 1988, with respect to accrual computation periods beginning after December 31, 1986. In the case of employees not employed after December 31, 1988, the provision applies to accrual computation periods beginning after December 31, 1988. A special effective date applies to collectively bargained plans.

Under the Senate amendment, plan amendments required by the provisions are not required to be made before the first plan year beginning on or after January 1, 1989, if (1) during the period after the amendment takes effect and before such first plan year, the plan is operated in accordance with the requirements of the Senate amendment, and (2) the plan amendment applies retroactively to the period after the amendment takes effect and before the first

plan year for which the provision is effective. A pension plan is not treated as failing to provide definitely determinable benefits merely because it operates in accordance with this delayed plan amendment provision.

The Senate amendment requires the Secretary of Labor or the Secretary of the Treasury to issue final regulations with respect to the provision by February 1, 1988.

Conference agreement

The conference agreement generally follows the Senate amendment with certain modifications.

Reasons for change.—When both ADEA and ERISA were enacted, authority for the administration and enforcement of both laws was the responsibility of the Secretary of Labor. Presidential Reorganization Plan No. 1 of 1978 transferred the authority for ADEA from the Secretary of Labor to the Equal Employment Opportunity Commission (EEOC), effective July 1, 1979.

Prior to that date, the Secretary of Labor issued an amendment to the Interpretative Bulletin on Employee Benefit Plans, 29 C.F.R. 860.120(f)(2)(ii) (relating to the application of sec. 4(f)(2) of ADEA to employee benefit plans covered under ERISA), which allowed employers to cease benefit accruals and allocations to an employee's account with respect to employees working beyond the normal retirement age under the plan.

On June 24, 1984, the EEOC announced that it intended to rescind the Department of Labor's interpretation and require employers to continue benefit accruals and allocations. In March 1985, the EEOC unanimously approved proposed regulations requiring such accruals and allocations. That proposed regulation has not been adopted or published in the *Federal Register*.

Disagreement exists as to whether and to what extent benefit accruals and allocations are required under ADEA, as currently in effect.

In the past three Congresses, bills have been introduced to require employers to continue benefit accruals and allocations. Hearings were held by the Subcommittee on Labor-Management Relations of the House Committee on Education and Labor on September 5, 1984, and by the Subcommittee on Aging of the Senate Committee on Labor and Human Resources on October 17, 1985, on those proposals.

In general.—Under the conference agreement, benefit accruals or continued allocations to an employee's account under either a defined benefit plan or a defined contribution plan may not be reduced or discontinued on account of the attainment of a specified age. A plan may impose a limitation on the amount of benefits provided under the plan or a limitation on the number of years of service or plan participation taken into account. The conferees intend that a plan should not be treated as violating the general rule merely because the plan limits benefits to a stated dollar amount or a stated percentage of compensation.

The conferees intend that the provisions of ADEA, ERISA, and the Code that are amended to prevent the reduction or cessation of benefit accruals on account of the attainment of age are to be interpreted in a consistent manner and do not intend any differences

in language in the provisions to create an inference that a difference exists among such provisions. (See, also, the discussion of interagency coordination, below.)

Under the conference agreement, a defined benefit plan may offset any benefit accruals required under the general rule by the amount of any adjustment in the benefits payable with respect to an employee attributable to a delay in the commencement of benefit payments after attainment of normal retirement age. A similar offset is available with respect to plans that provide for the commencement of benefit payments occurring before separation from service, but after the attainment of normal retirement age.

Under the conference agreement, the rules preventing the reduction or cessation of benefit accruals on account of the attainment of age are not intended to apply in cases in which a plan satisfies the normal benefit accrual requirements for employees who have not attained normal retirement age. Under the benefit accrual rules, the rate of benefit accrual for an employee may vary depending on the number of years of service an employee may complete between date of hire and the attainment of normal retirement age.

For example, under the fractional benefit accrual rule, an employee may accrue a benefit ratably for each year of service between the employee's date of hire and the employee's attainment of normal retirement age. If a plan has a normal retirement age of 65, under this fractional rule, an employee who is hired at age 45 would accrue the normal retirement benefit between age 45 and age 65 (normal retirement age). Thus, the employee would accrue the benefit over 20 years. On the other hand, an employee with the same salary hired at age 55 would accrue the same normal retirement benefit over 10 years (the number of years between date of hire and normal retirement age). In this example, when both employees have completed five years of service, they will have different accrued benefits because of the different rate of benefit accrual for each year of service. The conferees do not intend that the plan is to be treated as violating the general rule that benefit accruals cannot be reduced or ceased on account of the attainment of age merely because a younger employee has a lower accrued benefit than an older employee with the same number of years of service.

Exclusion from participation.—The conference agreement eliminates the provision in current law which permits an employer to exclude from participation under certain plans employees hired within five years of normal retirement age. The conferees believe that modification of the existing law in this way is consistent with the overall objective of the provisions to assure that employee benefit plans do not discriminate on the basis of age.

The conferees recognize that repeal of this rule may have the effect of increasing an employer's minimum funding requirements significantly for employees hired within five years of normal retirement age. In order to ease this effect, the conference agreement provides that a plan may extend the normal retirement age specified in the plan with respect to individuals who begin employment with the employer after attaining a specified age that is not more than five years before the normal retirement age under the plan. With respect to any such individual hired after the effective date, a plan may provide that normal retirement age may be no later than

the fifth anniversary of the time such participant commenced participation in the plan.

Target benefit plans.—The treatment of benefit accruals under a target benefit plan for employees who have attained normal retirement age is to be provided under regulations issued by the Secretary of the Treasury. The conferees expect that such regulations will provide that a plan is to take into account whether a participant's account balance is sufficient to provide the target benefit.

Highly compensated employees.—The conference agreement requires the Treasury to promulgate regulations that prescribe specific circumstances under which the benefit accrual and allocation requirements imposed by this amendment shall not apply to highly compensated employees. The conferees believe that such regulations are necessary because, in some situations, the requirements for continued benefit accruals or allocations may result in prohibited discrimination in favor of highly compensated employees.

While it is generally the view of the conferees that discrimination problems should be resolved by increasing the accrued benefits or allocations attributable to nonhighly compensated employees, the conferees understand that there may be circumstances under which such increases could (if made) result in violation of other plan qualification requirements specified in section 401(a) of the Code (including, for example, the limitations on contributions and benefits), or require employer contributions in excess of the deductible limits specified in section 404 of the Code. In such cases, the regulations are to provide methods for excluding highly compensated employees from the continued benefit accrual or allocation requirements.

Coordination with other provisions.—The conference agreement authorizes the Treasury to issue regulations coordinating the continuing benefit accrual requirements with other requirements, including the overall limits on contributions and benefits (sec. 415 of the Code), the nondiscrimination requirements applicable to qualified plans, tax-sheltered annuities, or SEPs, the coverage requirements (sec. 410 of the Code), the vesting requirements (sec. 203 of ERISA, and sec. 411 of the Code), the deduction limits (sec. 404 of the Code), and the Age Discrimination in Employment Act.

Integration of benefits.—The conference agreement does not follow the Senate amendment with respect to the special rules for integrated plans. The conferees believe that the new integration rules for qualified plans under the Tax Reform Act of 1986 make such special rules unnecessary because a plan is permitted under the Tax Reform Act to modify or reduce benefit accruals after a specified number of years of service. Thus, an integrated plan could avoid violation of the general benefit accrual requirement by ceasing benefit accruals after 35 years of service.

The conferees intend that Treasury regulations with respect to these provisions are to include special rules for periods during which the integration rules adopted in the Tax Reform Act are not effective.

Suspension of benefits.—The conference agreement does not alter the rules of existing law concerning the suspension of benefit payments to employees who are reemployed after attaining normal retirement age. Accordingly, a defined benefit plan complying with

the suspension of benefit rules is required to provide additional benefit accruals but would not have to recommence payments until the employee actually retires (unless the provisions of section 401(a)(9) of the Code require the commencement of benefits because the employee has attained age 70½).

For example, if a plan provides a benefit of \$10 monthly per year of service and an employee has 10 years of service at the plan's normal retirement age of 65, then the employee is entitled to receive a benefit of \$100 a month if he or she retires at age 65. If, however, the retiree is reemployed after age 65 and the plan contains a suspension of benefits provision, the plan is not required to pay any benefits during a period of reemployment, assuming that the requirements for suspending benefits under the Code and ERISA are satisfied. Pursuant to the conference agreement, the plan is required to provide an additional benefit of \$10 per month for each year of service after age 65 (until the employee has the maximum number of years of service for which credit is provided under the plan). Thus, at age 66, the retiring employee is entitled to receive a benefit of \$110 a month, but if the employee is reemployed, the \$110 may be forfeited under the suspension of benefit rules. Similarly, if the employee is to receive a benefit of \$120 at age 67 and the employee is reemployed the amount payable may be forfeited for the period of reemployment if the plan contains a suspension of benefits provision.

As under present law (Code sec. 411), a defined benefit plan must provide actuarially increased benefits if the suspension of benefit rules did not apply or were not applied. In such a situation, a plan will fail to satisfy the requirements of this amendment unless it provides each participant in the plan with additional accruals. However, the conference agreement provides that benefit adjustments provided under the plan to take account of the delayed commencement of benefits are to be credited to the additional accruals otherwise required. Thus, the value of benefits upon the actual commencement of benefits would effectively offset the additional accruals that are otherwise required under the plan.

If a plan pays retirement benefits to an employee who continues working after attainment of normal retirement age (and, therefore, neither suspends benefits nor actuarially increases benefits upon later separation from service), the provision of such benefit payments are in effect equivalent to the provision of an actuarial increase in benefits under a plan that delays the commencement of benefits (without satisfying the suspension of benefit rules). Accordingly, under the conference agreement, such a plan could offset the additional accruals required by this amendment by the value of the effective actuarial increase in benefits. The conferees intend that the Treasury will provide guidelines for computing the offset.

Exception for certain early retirement benefits.—Under the conference agreement, an exception is provided to the rules relating to continued benefit accruals with respect to benefit accruals to the extent they are attributable to subsidized early retirement benefits. The conferees intend that similar exceptions generally are to be provided with respect to other types of benefits, such as disability benefits or social security supplements, which are payable before

normal retirement age or the conditions of eligibility for which are not determined on the basis of age.

Age Discrimination in Employment Act.—It is the intention of the conferees, in adopting the amendments to ADEA (new sec. 4(i)), that the requirements contained in section 4(i) related to an employee's right to benefit accruals with respect to an employee benefit plan (as defined in sec. 3(2) of ERISA) shall constitute the entire extent to which ADEA affects such benefit accrual and contribution matters with respect to such plans on or after the effective date of such provisions (as described in the provision). No inference is to be drawn by the addition of section 4(i) as to whether or to what extent employee benefit plans might have been required to provide benefit accruals or allocations to employees' accounts for employees protected under ADEA prior to the effective date of section 4(i).

Effective date.—The conference agreement clarifies that the amendments apply to plan years beginning on or after January 1, 1988. Such amendments do not apply with respect to any employee who does not have an hour of service in any plan year to which the amendments apply. The provisions relating to the repeal of the provision which permits certain employees to be excluded from plan participation are effective for plan years beginning on or after January 1, 1988, with respect to hours of service on or after January 1, 1988. However, hours of service prior to January 1, 1988, shall be taken into account for purposes of section 410(a)(1)(A)(ii) and section 410(a)(1)(B) of the Code (relating to minimum service requirements) and the corresponding sections of ERISA, section 202(a)(1)(A)(ii) and section 202(a)(1)(B) of ERISA.

The conference agreement also limits the special effective date for plans maintained pursuant to a collective bargaining agreement to employees covered by such agreements. The conferees recognize that, as a result of the delayed effective date applicable to employees covered by a collective bargaining agreement, there may be situations in which a plan covering both employees who are covered by the agreement and those who are not so covered will be subject to two different effective dates. To the extent that the two effective dates may cause the plan to be considered discriminatory, the conferees intend that the Treasury will provide special rules ensuring that a plan will not fail to provide special rules ensuring that a plan will not fail to satisfy the nondiscrimination requirements applicable to qualified plans merely on account of the differing effective dates.

Interagency coordination.—The Secretary of Labor, Secretary of the Treasury, and the Equal Employment Opportunity Commission are to issue rulings and regulations that are consistent and are to consult and coordinate with one another in issuing such rulings and regulations.

10. PORT USE TAX AND RELATED TRUST FUND; INLAND WATERWAYS FUELS TAX AND RELATED TRUST FUND

Present law

Ports.—Present law does not impose Federal user taxes on the beneficiaries of Federal expenditures for development, operation, and maintenance of U.S. ports.

Inland waterways.—An excise tax of 10 cents per gallon is imposed on diesel and other liquid fuels used by commercial cargo vessels on designated inland or intracoastal waterways (Code sec. 4042). Amounts equivalent to the tax revenues are transferred to the Inland Waterways Trust Fund in the Treasury. Amounts in the Trust Fund are available, as provided by authorization and appropriations Acts, for construction and rehabilitation expenditures for navigation on the waterways covered by the fuels tax.

House bill

Port use tax and trust fund.—The House bill imposes an excise tax of 0.04 percent (4 cents per \$100) on the use of a U.S. port by a commercial vessel for loading or unloading of commercial cargo, effective January 1, 1987. Certain exemptions are provided.

Amounts equivalent to revenues from the tax are transferred to a Port Trust Fund established by the bill; also, the bill authorizes annual appropriations to the Trust Fund equal to \$1 billion less the port use tax revenue amounts transferred to the Fund. Amounts in the Port Trust fund are to be available, as provided by appropriations Acts, for specified port expenditures, and for rebates of Saint Lawrence Seaway tolls (U.S. portion) attributable to cargo subject to the port use tax. The statutory provisions for this Trust Fund are placed in the Trust Fund Code of the Internal Revenue Code. These provisions are effective January 1, 1987.

Inland waterways trust fund and fuels tax.—The House bill adds the Tennessee-Tombigbee Waterway to the list of designated waterways with respect to which the inland waterways fuels tax applies. Also, the bill places statutory provisions for the Inland Waterways Trust Fund in the Trust Fund Code of the Internal Revenue Code and makes certain changes relating to Trust Fund expenditures. These provisions are effective January 1, 1987.

Senate amendment

No provision.

Conference agreement

Port use tax and trust fund.—The conference agreement does not include the House bill provision.

Inland waterways trust fund and fuels tax.—The conference agreement does not include the House bill provision.

11. OIL SPILL LIABILITY TRUST FUND AND PETROLEUM TAX

Present law

Funds relating to oil spill damages and cleanups have been created under various statutes, including (1) section 311(k) of the Federal Water Pollution Control Act (Clean Water Act) ("Coast Guard

Fund"); (2) the Trans-Alaska Pipeline Authorization Act ("TAPS Fund"); the Deepwater Port Act of 1974 ("Deepwater Port Fund"); and the Outer Continental Shelf Act Amendments of 1978 ("Off-shore Oil Fund"). These funds are financed by per-barrel fees on crude oil ranging from two to five cents per barrel and, in the case of the Coast Guard Fund, by general revenue appropriations.

A tax of 0.79 cents per barrel was imposed on domestic crude oil and imported petroleum products as part of the funding for the Hazardous Substance Response Trust Fund ("Superfund"); this tax expired after September 30, 1985.¹

House bill

Oil spill liability trust fund

The House bill establishes in the U.S. Treasury the Oil Spill Liability Trust Fund ("Oil Spill Fund"). The general expenditure purposes of this fund are limited to payments, as provided in appropriation Acts, of (1) certain removal costs and related costs associated with oil spills; (2) claims asserted under the Comprehensive Oil Pollution Liability and Compensation Act ("COPLCA") that are not otherwise compensated; (3) administrative expenses incurred by the Federal Government under COPLCA; and (4) contributions to the International Fund for Compensation for Oil Pollution Damage ("International Fund") if the conventions establishing this fund come into force with respect to the United States.

Payments from the Oil Spill Fund may be made to a governmental entity only for removal costs and administrative expenses related to removal costs. Thus, for example, no amounts may be paid to any government for natural resource damage claims or loss of tax revenue.

Under regulations to be prescribed by the Treasury, expenditures from the Oil Spill Fund may be made for any contribution to the International Fund only in proportion to the portion of the International Fund that is used for purposes consistent with the expenditure purposes of the Oil Spill Fund.

Expenditures from the Oil Spill Fund are limited to \$200 million per incident. Except in the case of removal costs, payments may not be made from the Oil Spill Fund to the extent that the balance of such Fund following such payment would be less than \$30 million.

Under the House bill, the Oil Spill Fund is authorized to borrow up to \$300 million. Advances made to the Oil Spill Fund are repayable with interest to the general fund of the Treasury. Interest accrues, with annual compounding, at a rate equal to the current average yield on outstanding marketable U.S. obligations with remaining maturity equal to the anticipated period over which the advance will be outstanding, as determined by the Secretary. All advances must be repaid no later than September 30, 1991.

¹ The conference agreement on H.R. 2005 (The Superfund Amendments and Reauthorization Act of 1986), as passed by the Senate on October 3, 1986, and the House of Representatives on October 8, 1986, reimposes the prior-law excise tax on petroleum at a rate of 8.2 cents per barrel on domestic crude oil and 11.7 cents per barrel on imported petroleum products, effective January 1, 1987. A credit is added for certain crude oil which is returned to a pipeline.

Claims asserted under COPLCA may not be paid from any source other than the Oil Spill Fund. Claims against the Oil Spill Fund are to be paid in full in the order in which they are finally determined, subject to the expenditure limitations described above.

Excise tax on petroleum

Under the House bill, the Oil Spill Fund is financed in part by an excise tax of 1.3 cents per barrel on crude oil and imported petroleum products ("oil spill tax"). The tax is imposed on the same crude oil and petroleum products, and is subject to the same definitional and other provisions, as the Superfund petroleum tax (sec. 4611) which expired on September 30, 1985. The collection, enforcement, and penalty provisions also are the same as under the Superfund petroleum tax.

A credit against the oil spill tax is allowed for amounts paid by the taxpayer before 1987 into the Deepwater Port Fund or the Offshore Oil Fund.

Effective date

The oil spill tax is effective January 1, 1987, through December 31, 1991. The Oil Spill Liability Trust Fund provisions are effective January 1, 1987.

Senate amendment

No provision.

Conference agreement

Oil spill liability trust fund

The conference agreement follows the House bill, except that—

(1) The Oil Spill Fund is authorized to borrow up to \$500 million from the general fund of the Treasury, subject to the same conditions as under the House bill.

(2) The liability of the Oil Spill Fund cannot exceed \$500 million for any single incident. (The conference agreement retains the restriction on any payment, other than for removal costs, that would reduce the fund balance below \$30 million.)

(3) Payments from the Oil Spill Fund may be made to a governmental entity only for (A) removal costs and administrative expenses related to removal costs, and (B) natural resource damage claims not in excess of \$250 million per incident and related administrative expenses.

(4) All references to COPLCA are treated as references to any authorizing legislation that is substantially identical to subtitle E of Title VI or subtitle D of Title VIII of H.R. 5300,² as passed by the House on September 24, 1986. If no such legislation is enacted by September 1, 1987, the trust fund provisions would never take effect (see effective dates, below).

Under rules to be prescribed by the Treasury, expenditures from the Oil Spill Fund may be made for any contribution to the Inter-

² These correspond to the oil spill liability and compensation provisions as reported by the House Committee on Merchant Marine and Fisheries and the House Committee on Public Works and Transportation, respectively, each of which is included in H.R. 5300.

national Fund only in proportion to the portion of the International Fund that is used for purposes consistent with the expenditure purposes of the Oil Spill Fund. The conferees intend that the portion of any contribution made to the International Fund that is paid out of the Oil Spill Fund shall be limited to the portion of the expenditures from the International Fund (after the date of enactment of authorizing legislation) that are made for purposes consistent with those of the Oil Spill Fund. (If the International Fund has made no expenditures for any purpose, no limitation would apply.) Expenditures by the International Fund that are inconsistent with the purposes of the Oil Spill Fund include, but are not limited to, payments to national or subnational governments (or agencies thereof) to the extent such payments are for (1) replacement of tax revenues, or (2) natural resource damage assessments and claims in excess of \$250 million per incident.

Excise tax on petroleum

The conference agreement follows the House bill, with the following modifications:

First, if the Superfund Amendments and Authorization Act of 1986 is enacted, the tax would be imposed on the same crude oil and petroleum products as would be taxed under Code section 4611 (Superfund tax on petroleum) as amended by that Act.

Second, the excise tax on petroleum is to terminate when cumulative revenues from the tax reach \$300 million. (This provision applies only to the portion of the petroleum tax used to finance the Oil Spill Fund.)

Third, the credit for previous contributions to the Deepwater Port Fund or the Offshore Oil Fund is to include the contributors' share of accrued interest on contributions, determined as of January 1, 1987.

Effective date

The Oil Spill Fund provisions and the tax on domestic and imported oil will be effective on the beginning of the first month occurring more than 30 days after enactment of authorizing legislation, but in no event will such provisions and taxes be effective before February 1, 1987. The taxes and trust fund provisions will never become effective if authorizing legislation is not enacted by September 1, 1987.

12. APPROPRIATIONS FOR IRS ENFORCEMENT

Present law

The Internal Revenue Service (IRS) is responsible for administering almost all of the tax laws. The cost of the entire IRS budget is funded through annual appropriations of general revenues.

House bill

The House bill provides for increases in the funding levels appropriated to specific IRS functions for fiscal year 1987. Increased funds are to be directed to functions involving examination, collection, and related tax compliance activities, as follows:

Salaries and expenses	\$95,147,000
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Processing tax returns.....	1,332,902,000
Examinations and appeals.....	1,623,162,000
Investigation, collection, and taxpayer service.....	1,196,581,000

These changes in funding are to be effective only if the allocation to the Senate Appropriations Committee for the budget for fiscal year 1987 for the IRS is increased by \$300 million in both new budget authority and outlays.

Senate amendment

The Senate amendment generally is the same as the House bill.

Conference agreement

The conference agreement follows the House bill.

VI. OTHER PROVISIONS

1. CUSTOMS USER FEES (SECS. 8351 AND 8352 OF CONFERENCE AGREEMENT; SEC. 10361 OF HOUSE BILL; NO SENATE PROVISION)

Present law

The Consolidated Omnibus Budget Act of 1985 (P.L. 99-272) for the first time imposed a schedule of customs user fees to cover Customs' costs of processing the arrival of vessels, trucks, trains, private boats and planes, and passengers. No fees were imposed, however, on the processing of commercial merchandise. The total revenues from such fees are approximately \$170 million per year.

House bill

Imposes a customs user fee on all formal entries of imported merchandise for consumption based on the customs value of such merchandise of 0.5 percent ad valorem for the period December 1, 1986, through September 30, 1987, and 0.2 percent ad valorem thereafter. The provision would not apply to informal entries or to articles classifiable under items in schedule 8 of the Tariff Schedules. These fees would be in addition to the processing fees required under present law. The proceeds of such fee would be deposited in a separate account within the general fund of the Treasury and be available, subject to appropriation, to the Customs Service for carrying out its operations.

On September 30, 1988, and every two years thereafter, the Secretary of the Treasury would be required to submit a report to the Congress concerning any necessary fee adjustments to bring the account into a zero balance and to ensure that the fee reflects the actual costs of the services provided.

Senate amendment

No provision.

Conference agreement

The conferees agreed to an amended version of the House provision imposing a user fee of 0.22 percent ad valorem in fiscal year 1987 and 0.17 percent ad valorem in fiscal years 1988 and 1989 on all formal entries of imported merchandise for consumption, beginning December 1, 1986, based on the appraised customs value of

such merchandise. These fees would be in addition to the processing fees required under present law and all such fees would expire at the conclusion of fiscal year 1989. The provision would not apply to articles classifiable under items in schedule 8 of the Tariff Schedules or to the products of least developed developing countries (LDDCs), eligible countries under the Caribbean Basin Initiative (CBI), or U.S. insular possessions. The proceeds of such fees would be deposited in a dedicated account within the general fund of the Treasury and be available, subject to authorization and appropriation, to offset appropriations to the Customs Service for the cost of commercial services rendered. In fiscal years 1988 and 1989, a special formula would allow reduction of the fee if that became necessary to ensure that the fee structure and revenue derived therefrom in the outyears of the program are consistent with the international obligations of the United States.

During the effective period of the customs user fees, Customs would be precluded from assessing charges for cargo inspection or clearance services or any other customs service performed or personnel provided in connection with the arrival or departure of any commercial vessel, vehicle, or aircraft, its passengers, crew, and cargo, including those performed outside of normal business hours on an overtime basis and those performed outside of the United States except for those fees authorized under subsection (a) of section 13031 of the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended by this Act. This provision includes, in section 8352, an authorization of appropriations for the U.S. Customs Service for fiscal year 1987 of \$1,001,180,000 to serve as a measure of limitations applicable to such fees under existing international trade agreements.

The fee is intended to apply to all formal entries of merchandise for consumption, including warehouse withdrawals for consumption. The fee would not apply, however, to informal entries, merchandise which does not formally enter U.S. commerce for consumption, or any articles which are eligible for special tariff treatment under one of the provisions in schedule 8 of the Tariff Schedules of the United States. The conferees also agreed to exclude the products of U.S. insular possessions, LDDCs, and CBI countries from the application of this fee primarily because these are among the poorest nations in the world and the General Agreement on Tariffs and Trade (GATT) authorizes signatories to provide special and differential treatment to developing countries.

The conferees intend that the exemption for articles entering under schedule 8 shall include the full value of items which, if dutiable, would be eligible for entry under TSUS items such as items 806.30 or 807.00, even if the articles are currently duty-free under the parent provision.

The fee would apply to all other articles, however, regardless of whether such articles are dutiable or duty-free or whether the articles are eligible for a tariff preference such as the Generalized System of Preferences (GSP) or a bilateral free trade arrangement.

In the case of small airports and other facilities where the entire cost of maintaining customs services is already borne by the users of such facilities, the Secretary of the Treasury would be author-

ized to impose a lower merchandise entry fee than would be applicable otherwise.

The conferees believe that a necessary corollary to the imposition of a merchandise user fee is adequate and expeditious customs processing of such merchandise. The importing community has a right to expect the Customs Service to be adequately staffed and to provide its services in an expeditious fashion. It is the intention of the conferees in providing for a customs user fee for cargo shipments, that such a fee will enable the Customs Service to guarantee that staffing and services will be provided at such times and at such levels as are necessary to meet the demand of the shipping public.

The conferees are also concerned that the creation of a user fee on consumption entries not be the occasion for an increase in the recordkeeping or other data collection burdens imposed upon the public. In this regard, it is anticipated that the Customs Service will continue to employ its existing standard consumption entry form (CF 7501) which contains sufficient information to assure proper collection of the user fee. In implementing the new user fee, the conferees direct the Commissioner of Customs to make certain that no new recordkeeping or data collection burdens are imposed upon the public, including all shippers, cargo-freight carriers, or related entities.

The new fees are consistent with U.S. obligations under the GATT. These fees are limited in amount to the approximate cost of services rendered by the Customs Service, and the fees are therefore consistent with the GATT exceptions regarding such charges. Article II, section 2, of the GATT authorizes any contracting party to impose at any time on the importation of any product "fees or other charges commensurate with the costs of services rendered." Article VIII is to similar effect. Moreover, Article XX of the GATT, entitled "General Exceptions," allows the United States to adopt any measure "necessary to secure compliance with laws . . . including those relating to customs enforcement. . . ." Since customs enforcement involves inspection and various duty collections over and above commercial operations, the fee does not cover all operations that such a fee may cover under GATT.

An overall ad valorem fee is the only way to equitably distribute the cost of Customs' commercial services. In line with GATT Article VIII, the fee is limited to the approximate cost of these services. The total revenues of approximately \$170 million per year realized from the existing fees fall far short of covering the costs of services rendered by the Customs Service. The additional fees have been limited to less than the cost of all services rendered.

The fee level of 0.22 percent ad valorem in fiscal year 1987 was adopted because the CBO revenue estimate of \$790 million in fiscal year 1987, which provides the basis for revenue scoring under the Budget Act, is based upon a CBO estimate of imports of \$436.6 billion in that fiscal year. The conferees are advised by the Administration that imports in fiscal year 1987 will actually be significantly lower than the CBO estimate, largely because of the impact of the declining value of the U.S. dollar. Based on annualized trade data for the first six months of calendar year 1986 and the estimated effect of the decline in the value of the dollar, a more realistic

projection of imports for fiscal year 1987 would be approximately \$366.2 billion or \$70 billion less than the CBO estimate. On the basis of this figure, the actual revenues realized from the user fee will be about \$630 million which, together with the \$170 million currently being collected, closely approximates the \$830 million salary and expense figure authorized in this legislation for fiscal year 1987.

Second, the conferees opted for a slightly higher fee in the first year to ensure that there are adequate receipts in the fund to cover start-up costs and to cover any potential increases in the costs of customs operations. In this regard, the fee was reduced to 0.17 percent ad valorem after only 10 months of operation on the belief that, after the start-up costs were absorbed, the lower fee in subsequent years would offset any surplus resulting in fiscal year 1987, so that for the first two years the fees realized will closely approximate Customs' actual costs of commercial operations.

Third, beginning in fiscal year 1988, a mechanism is provided which would authorize the Secretary of the Treasury to reduce the applicable fee so that the amount realized from such fees would be reduced in an equivalent amount to any reductions in the amount appropriated to the U.S. Customs Service for commercial operations. The conferees are concerned that in future years, the amount authorized for the Customs Service would, in some part, not be appropriated, and therefore the fee provided for in fiscal years 1988 and 1989 in the conference agreement (which must, under the Budget Act, be established now in order to count as savings with respect to those years) would be higher than is consistent with the standard of Article VIII of the GATT. To answer this concern, the conferees have established a "fee reduction mechanism" applicable in fiscal years 1988 and beyond, which provides that the fee is the lower of the fee set by this bill or an ad valorem rate the Secretary of the Treasury is required to set in accordance with a formula. The formula requires that the Secretary reduce the rate of the fee to produce revenue each year equal to the amount authorized for salaries and expenses for commercial operations of the Customs Service in that same year. This authorization amount, as well as the fee, is required by the bill to be explicitly authorized each year.

All customs user fees, whether derived from merchandise entries or otherwise, are to be deposited in a dedicated account in the General Fund of the Treasury, to be used exclusively to reimburse the Customs Service appropriation. The fee reduction mechanism which is authorized for fiscal years 1988 and 1989 should ensure that the balance in this account is reduced to zero by the close of fiscal year 1989.

Finally, in order to ensure that the fees approximate the actual costs of Customs' operations, the Secretary is directed at the end of fiscal year 1988 and every two years thereafter to recommend corrections in the fee structure in order to bring the funds in the dedicated customs user fee account to a zero balance. Accordingly, the conferees chose to adopt a cautious approach and to approve a fee structure which would *guarantee* adequate funding at the outset and strive for overall balance in the ensuing years in a manner that is completely consistent with our obligations under the GATT.

2. TEMPORARY INCREASE IN PUBLIC DEBT LIMIT

The amount available for the debt limit through May 1987, \$2,300 billion, is consistent with the budget totals and budget deficits in the Budget Resolution adopted by Congress for fiscal year 1987. The increase of \$189 billion would expire on May 15, 1987 and the debt limit will revert to its permanent level of \$2,111 billion.

3. RESTORATION OF LOST INTEREST TO CERTAIN TRUST FUNDS

The conference agreement provides for the restoration to certain Federal trust funds of lost interest and obligations due to any non-investments, redemptions, or disinvestments that occurred as a result of the failure to extend the debt limit by September 30, 1986. This provision places those trust funds that experienced any disruption in normal investment and redemption procedures due to debt ceiling constraints in the same position they would have been in had H.J. Res. 668, as passed by the House of Representatives on June 26, 1986, been enacted into law on September 30, 1986.

MEDICAID PROVISIONS

1. OPTIONAL COVERAGE FOR POOR PREGNANT WOMEN AND CHILDREN (SECTION 9401)

Present law

States are required to provide Medicaid coverage to all children receiving assistance under the Federally-assisted Aid to Families with Dependent Children (AFDC) program and may provide coverage for children who would be eligible for AFDC except for income requirements (known as the medically needy). States are required to cover all children born after October 1, 1983, up to age 5 who meet the AFDC income and resources requirements and may extend coverage to all such children under age 5 immediately. States are also required to cover pregnant women meeting AFDC income and resources standards.

House bill

(a) New optional categorically needy group.—

(i) Creates a new optional categorically needy group composed of pregnant women (through 60 days following pregnancy) and infants up to 1 year of age with family incomes up to the Federal poverty level. A State choosing this option could not elect to cover only pregnant women or only children.

(ii) Provides that States could choose an income eligibility level between the AFDC payment level and 100 percent of the Federal poverty line. The State is required to use the same methodology used in determining eligibility for AFDC benefits. Costs incurred for medical care are not taken into account in determining eligibility.

(iii) Prohibits States from setting a resource standard for newly eligible pregnant women. For infants, States are not permitted to apply a resource standard that is more restrictive than the AFDC standard; they are permitted to use the SSI re-

source standard; some other less restrictive resource test; or to impose no resource requirements at all.

(iv) Specifies that any different treatment of income and resources provided for newly eligible persons shall not require or permit such treatment for other persons.

(v) Provides that if a State chooses to cover a new optional categorically needy group, it may not lower its AFDC payment levels below those in effect on April 17, 1986.

(b) *Benefits*.—Specifies that newly covered pregnant women are only entitled to services related to pregnancy (including prenatal, delivery, and postpartum services) and other conditions which complicate pregnancy.

(c) *Continuation of assistance*.—

(i) Permits a State to treat pregnant women eligible under this provision as eligible for Medicaid throughout their pregnancy without regard to any change in family income.

(ii) Requires States to extend eligibility for an infant receiving inpatient services on his/her first birthday until the end of the inpatient episode.

Senate amendment

(a) *New optional categorically needy group*.—

(i) Similar provision except that beginning in FY 88 States could increase the age level by one year in each fiscal year until all children up to age 5 were included. States could not elect to cover one age group unless children in all younger age groups were covered.

(ii) Similar provision except does not specify that the minimum level is the AFDC level.

(iii) Specifies that application of a resources standard is at a State option. The State may choose the resources standard and methodology used under AFDC, SSI, or the medically needy programs; or

(iv) Identical provision.

(v) Similar provision except linked to enactment.

(b) *Benefits*.—Identical provision.

(c) *Continuation of assistance*.—

(i) Identical provision.

(ii) Identical provision except also includes newly eligible children.

Conference agreement

(a) *New optional categorically needy group*.—

(i) The conference agreement follows the Senate amendment.

(ii) The conference agreement follows the Senate amendment.

(iii) The conference agreement follows the Senate amendment with a modification. In the case of pregnant women, the States would be allowed to impose resource standards and methodologies that are no more restrictive than those under the SSI program. In the case of infants and children, the States would be allowed to impose resource standards and methodologies no more restrictive than those under their AFDC pro-

grams. As under current law, AFDC sibling and grandparent deeming rules would not apply to this population.

(iv) The conference agreement follows the Senate amendment.

(v) The conference agreement follows the House bill.

(b) *Benefits.*—The conference follows the Senate amendment.

(c) *Continuation of assistance.*—The conferenced agreement follows the Senate amendment with respect to items (i) and (ii).

Effective date.—Except for the phased-in coverage of children, applies to medical assistance furnished in calendar quarters beginning on or after April 1, 1987. The phased-in coverage for children begins October 1, 1987 and is extended in 1-year intervals until October 1, 1990, when all newly eligible children under age 5 may be covered. These options are effective on the dates specified whether or not final regulations have been promulgated by those dates.

2. OPTIONAL PRESUMPTIVE ELIGIBILITY PERIOD FOR PREGNANT WOMEN (SECTION 9407)

Present law

Title XIX of the Social Security Act allows for a 3-month retroactive eligibility period prior to the date on which application for medical assistance is made. Medicaid regulations further require State agencies to determine eligibility within 45 days from the day of the application for benefits. If the application is approved, medical expenses incurred during the 3-month retroactive eligibility period and services incurred after the date of application for benefits are reimbursed under the normal Medicaid rules. If the application is denied, medical expenses incurred during the 3-month retroactive eligibility period and services incurred after the day of application remain the responsibility of the individual.

House bill

No provision.

Senate amendment

Permits States to make ambulatory prenatal care available to pregnant women during a presumptive period of eligibility which is defined as: (1) beginning on the date on which a qualified provider determines on the basis of preliminary information that the family income falls below the applicable Medicaid standard; and (2) ending on the earlier of the day on which the application is approved or disapproved by the State agency or 45 days after the date the provider makes the determination. A qualified provider (1) is eligible for Medicaid payments; (2) provides outpatient hospital services, rural health services, or clinic services; (3) is determined by the State agency to be capable of making presumptive eligibility determinations; and (4) receives funds under the migrant health centers, community health centers, or the maternal and child health block grant programs; participates under the Special Supplemental Food Program for Women, Infants and Children or the Commodity Supplemental Food Program; or participates in a State perinatal program. The State agency is required to provide qualified providers with necessary application forms and information on how to assist

pregnant women to complete the forms. A provider that determines a woman is presumptively eligible is required to notify the State agency within 5 working days of the determination. The provider also must inform the woman at the time the determination is made that she is required to apply for Medicaid within 14 days of the determination, and the woman is required to make such application. Payments made on behalf of presumptively eligible women shall be at the same rate otherwise applicable. The amounts of any excess payment under this provision are not to be included toward the calculation of excess payments under the State's quality control program.

Conference agreement

The conference agreement follows the Senate amendment with a clarification that the provision is effective on April 1, 1987, without regard to whether final regulations have been promulgated by that date. The conference agreement further clarifies that, in the case where a pregnant woman does not file a Medicaid application within the required 14 day period, the woman's presumptive eligibility terminates at the end of the 14 day period.

Effective date.—Applies to ambulatory prenatal care furnished in calendar quarters beginning on or after April 1, 1987, without regard to whether final regulations have been promulgated by that date.

3. OPTIONAL COVERAGE OF ELDERLY AND DISABLED POOR FOR ALL MEDICAID BENEFITS (SECTION 9402)

Present law

Eligibility of the elderly and the disabled for Medicaid is linked to actual or potential receipt of cash assistance under the Federal Supplemental Security Income (SSI) program. The elderly and the disabled covered under Medicaid generally are persons receiving Federal and/or State SSI payments, residing in a skilled nursing facility or intermediate care facility, or incurring substantial medical expenses. The income and resource eligibility criteria differ substantially among the States.

House bill

(a) *New optional categorically needy group.*—Creates a new optional categorically needy group composed of the aged and disabled with family incomes up to the Federal poverty level. A State choosing this option would have to offer the benefit package available to other categorically needy recipients. A State choosing this option would also have to cover some newly eligible pregnant women and children.

(b) *Income and resources standards.*—Provided that States could choose an income eligibility level up to 100 percent of the Federal poverty line. Costs incurred for medical care are not taken into account in determining eligibility. Required States to use SSI resource standards, except that if a State has a medically needy program utilizing higher resource standards, it may utilize those higher standards. Specifies that any different treatment of income

and resources provided for newly eligible persons shall not require or permit such treatment for other persons.

Senate amendment

(a) *New optional categorically needy group.*—Identical provision.

(b) *Income and resources standards.*—Identical provision.

Conference agreement

The conference agreement follows the Senate amendment.

Effective date.—Applies to payments to States for calendar quarters beginning on or after July 1, 1987, without regard to whether final regulations have been promulgated by that date.

4. OPTIONAL COVERAGE OF POOR MEDICARE BENEFICIARIES FOR
MEDICARE COST-SHARING EXPENSES (SECTION 9403)

Present law

Coverage under Medicare Part B requires payment of monthly premium. Most States make this payment for their Medicaid eligibles under a "buy-in" agreement. While States may buy into Medicare for both their cash assistance and non-cash assistance populations who are eligible for Medicare, Federal matching for premium payments is only available for the cash assistance group.

States may receive Federal matching payments for Medicare cost-sharing charges, including deductibles and coinsurance, for services provided to their dual eligibles.

House bill

(a) *New optional coverage group for medicare cost-sharing.*—

(i) Creates a new optional coverage group composed of Medicare Part A beneficiaries not otherwise eligible for Medicaid with family incomes up to the Federal poverty level. A State choosing this option would also have to cover some newly eligible pregnant women and children.

(ii) Provides that States could choose an income eligibility level up to 100 percent of the Federal poverty line. Costs incurred for medical care are not taken into account in determining eligibility.

(iii) Requires States to use SSI resource standards, except that if a State has a medically needy program using higher resource standards, it may apply those higher standards to this group.

(iv) Specifies that any different treatment of income and resources provided for newly eligible persons shall not require or permit such treatment for other persons.

(b) *Benefits.*—Specifies that covered benefits are limited to Medicare cost-sharing. Medicare cost-sharing is defined as Part B premiums, Part A deductibles and coinsurance, Part B deductibles and Part B coinsurance. The term may include, at the option of the State, premiums for enrollment of an eligible beneficiary with a Medicare-qualified risk-sharing HMO.

(c) *Payment amounts.*—Provides that the total of Medicaid payments for Medicare cost-sharing charges under this provision to-

gether with Medicare payments may exceed the amounts otherwise payable under the State Medicaid plan for such services.

(d) *Effective date of benefits.*—Specifies that if an individual is determined to be a qualified Medicare beneficiary as defined under this provision, the determination shall apply to services furnished after the end of the month in which the determination first occurs. The determination shall be considered to be valid for a 12-month period, except that a State may provide for more frequent determination, but not more frequently than every six months.

Senate amendment

(a) *New optional coverage group for medicare cost-sharing.*—Identical provision.

(b) *Benefits.*—Identical provision except includes (if applicable) Part A premiums.

(c) *Payment Amount.*—Identical provision.

(d) *Effective Date of Benefits.*—Identical provision.

Conference agreement

The conference agreement follows the Senate amendment.

Effective date.—Applies to payments under Medicaid for calendar quarters beginning on or after July 1, 1987, without regard to whether final regulations have been promulgated by that date.

5. MEDICAID ELIGIBILITY FOR QUALIFIED SEVERELY IMPAIRED INDIVIDUALS (SECTION 9404)

Present law

Low-income individuals who qualify for Medicaid on the basis of disability must, in most States, meet the disability standards of the Supplemental Security Income (SSI) program. (Some States have opted to impose more restrictive criteria than those in SSI. These are commonly referred to as the "209(b) States" in reference to the statutory provision which gives them the option to use their 1972 eligibility standards for the elderly and disabled). For purposes of SSI, an individual is not considered to be disabled if, after a 9-month trial work period, he or she is able to engage in "substantial gainful activity" (SGA) which the Secretary has defined as average countable earnings of over \$300 per month. Loss of disability status for SSI purposes means loss of categorical eligibility for Medicaid.

The Disability Amendments of 1980 (P.L. 96-265) added a new section 1619 to the SSI law. Section 1619(a) provides that an individual who loses eligibility for SSI because he or she has worked and demonstrated the ability to engage in SGA, but who continues to have a disabling impairment, may become eligible for a special cash benefit equal in amount to an SSI benefit until his or her countable income reaches the SSI income disregard "break-even" point (in 1986, \$756 per month in a State with no supplementation). Those who qualify for these special SSI benefits continue to be eligible for Medicaid as long as they need medical assistance to continue working.

Section 1619(b) provides Medicaid coverage for individuals whose earnings cause their income to exceed the SSI income disregard "break-even point". This special Medicaid eligibility status applies

so long as the individual: (1) continues to be blind or have a disabling impairment; (2) except for earnings, continues to meet all the other requirements for SSI eligibility; (3) would be seriously inhibited from continuing to work by the loss of Medicaid coverage; and (4) has earnings that are not sufficient to provide a reasonable equivalent of the Medicaid and SSI benefits that would have been available if he or she did not work. The Social Security Administration (SSA) has established a "threshold" in each State based on SSI and any State supplementation and the State's average per capita Medicaid expenditures; individuals with gross earnings in excess of this "threshold" no longer meet requirement (4) and therefore lose Medicaid coverage, unless their individual medical expenses exceed the State's average Medicaid expenditures.

According to SSA, section 1619 has enabled thousands of former SSI recipients to retain Medicaid coverage despite returning to work and performing SGA. Section 1619 expires on June 30, 1987.

House bill

Amends Title XIX of the Social Security Act to establish a new mandatory, categorically needy coverage group: "qualified severely impaired individuals." This group includes any individual under 65 who received either SSI, State supplementation, or special 1619(a) benefits and who: (1) continues to be blind or have a disabling physical or mental impairment; (2) except for earnings, continues to meet all other requirements for SSI eligibility (including the limitations on unearned income below the SSI benefit standard); (3) would be seriously inhibited by the lack of Medicaid coverage from continuing to work or from obtaining employment; and (4) has earnings that are not sufficient to provide a reasonable equivalent of the Medicaid, SSI, and Title XX attendant care benefits that would be available if he or she did not work. This mandatory coverage group applies both in States that currently follow the SSI definition of disability and in the "209(b)" States.

Senate amendment

No provision. In September, the Senate Finance Committee reported S. 2209, S. Rept. 99-466, which revises and makes permanent the provisions of section 1619 of the Social Security Act. This legislation, in different versions, has passed both Houses.

Conference agreement

The conference agreement follows the House bill with a clarification that, in order to qualify for Medicaid coverage under this provision, an individual must have eligible for Medicaid in the month preceeding the first month in which this provision applies to the individual. The conferees assume that section 1619(a) will be revised and made permanent in other legislation, in which case the Secretary, through the Social Security Administration, will continue to administer eligibility for Medicaid benefits for this population. Should the section 1619(a) authority expire, however, the Secretary may make other arrangements, if the Secretary finds it appropriate to do so.

Effective date.—Applies to payments for calendar quarters beginning on or after July 1, 1987, without regard to whether regula-

tions to implement these amendments have been promulgated by such date. Delay would be permitted where State legislation is required to amend the State's Medicaid plan.

6. CLARIFICATION OF ELIGIBILITY OF HOMELESS INDIVIDUALS (SECTION 9405)

Present law

States are prohibited from imposing residency requirements that exclude any otherwise qualified individual who resides in the State. There is no Federal requirement that an individual have a fixed or permanent residence in order to qualify for Medicaid. However, according to the Department of Health and Human Services and the General Accounting Office, some States and localities require applicants for Medicaid and AFDC to supply a fixed address in order to qualify. It appears that these requirements are imposed out of concern by the States that the Federal government will penalize them if they approve fraudulent applications for homeless recipients.

House bill

Clarifies that States or localities are prohibited from imposing any residence requirement which excludes from Medicaid any otherwise qualified individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

Effective date.—Enactment.

7. TREATMENT OF INCOME AND RESOURCES REQUIRED TO BE PAID UNDER SPOUSAL AND CHILD SUPPORT

Present law

The Medicaid statute provides that, in determining eligibility, States take into account only such income and resources as are available to the applicant or recipient, in accordance with standards prescribed by the Secretary.

House bill

Clarifies that in determining the income and resources of an individual who is in an institution, the individual shall not be considered to have available to him or her income or resources which are required to be paid under court order for the support of the individual's spouse or child. The provision applies to States which had the policy or practice of disregarding such support payments in such circumstances as of July 22, 1986, without regard to whether or not the policy or practice, reflected in a State plan amendment or not, was approved by HCFA.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

8. PAYMENT FOR ALIENS UNDER MEDICAID (SECTION 9406)

Present law

The Medicaid statute does not explicitly identify whether otherwise qualified aliens are entitled to benefits. By regulation, the Secretary has limited Medicaid eligibility to otherwise eligible aliens who are lawfully admitted for permanent residence or permanently residing in the U.S. under color of law, including any alien who is lawfully present under sec. 203(a)(7) or sec. 212(d)(5) of the Immigration and Nationality Act. The Aid to Families with Dependent Children (AFDC) statute, section 402(a)(33) of the Social Security Act, and the Supplemental Security Income (SSI) statute, section 1614(a)(1)(B) of the Act, both limit eligibility for cash assistance benefits to otherwise qualified aliens who are lawfully admitted for permanent residence or otherwise permanently residing in the U.S. under color of law.

On July 14, 1986, a U.S. District Court struck down this regulation as outside the scope of the authority delegated under the Medicaid statute. The court reasoned that Congress "knew how to impose alienage requirements on social welfare programs when it intended, and its refusal to impose such a requirement on Medicaid should be respected." Because the AFDC and SSI statutes do include explicit exclusions of certain classes of aliens, the result of this decision is that otherwise qualified aliens who are eligible for Medicaid as non-cash beneficiaries—i.e., medically needy or optional categorically needy individuals—are entitled to Medicaid coverage.

House bill

Amends the Medicaid statute at section 1903(i) to make it explicit that Federal financial participation is not available for State expenditures for aliens who are not lawfully admitted for permanent residence or permanently residing in the U.S. under color of law. Further provides in sec. 1902(a) that nothing in Medicaid law should be construed to require a State to offer coverage to aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the U.S. under color of law.

Senate amendment

No provision.

Conference agreement

The conference agreement follows that House bill with a modification providing that Federal financial participation is not available for State expenditures for aliens who are not lawfully admitted for permanent residence or permanently residing in the U.S. under color of law except where the alien is otherwise qualified for Medicaid and has an emergency medical condition. In order to oth-

erwise qualify for Medicaid as a categorically needy beneficiary, an alien need not actually receive a cash payment under AFDC or SSI (indeed, current law precludes payment in such cases); however, the alien must meet the income, resource, and categorical requirements of the applicable cash assistance program. An emergency medical condition is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The costs of hospitals and other providers delivering necessary services covered under the Medicaid State plan to aliens with emergency medical conditions are therefore allowable under Medicaid so long as the alien meets the applicable income, resource, and categorical eligibility requirements under the State Medicaid plan.

Effective date.—Applies to medical assistance furnished to aliens on or after January 1, 1987, whether or not final regulations have been promulgated by that date.

9. PERMITTING STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES TO LOW-INCOME INDIVIDUALS WITH AIDS-RELATED CONDITIONS (SECTION 9411)

Present Law

(a) *Eligibility for persons with AIDS or AIDS related conditions.*—Section 1915(c) of the Social Security Act authorizes the Secretary to waive certain Medicaid requirements to allow States to provide a variety of home and community-based long-term care services to individuals (1) who would otherwise require the level of care provided in a SNF or ICF whose cost could be reimbursed under the State plan, or (2) who but for the provision of these services would continue to receive inpatient hospital, SNF, or ICF services because they are dependent on ventilator support whose cost is reimbursed under the State plan.

(b) *Computing expenditures for AIDS patients.*—In order to receive approval for a waiver, States must provide a number of assurances to the Secretary, including one requiring that the estimated average per capita expenditure for medical assistance under the waiver for those receiving waived services in any fiscal year not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been incurred in that year for that population if the waiver had not been granted. COBRA allowed States, in estimating average per capita expenditures for waivers applying only to physically disabled individuals in SNFs or ICFs, to use only the expenditures associated with this group of persons and not expenditures associated with other eligible individuals.

(c) *Providing case management services to AIDS patients.*—Section 1915(g) authorizes the Secretary to provide case management services without regard to requirements that Medicaid services be available throughout a State and that covered services be equal in amount, duration, and scope for certain Medicaid recipients. Case

management services are defined as services which will assist individuals eligible under the State's Medicaid plan in gaining access to needed medical, social, educational, and other services.

House bill

(a) *Eligibility for persons with AIDS or AIDS-related conditions.*—Extends eligibility for home and community-based services to individuals diagnosed as having AIDS or AIDS-related conditions who, but for such services, would continue to receive inpatient hospital care the cost of which is reimbursed under the State plan.

(b) *Computing expenditures for AIDS patients.*—Allows States, in estimating average per capita expenditures for waivers applying only to persons with AIDS or AIDS-related conditions who are in hospitals, SNFs, or ICFs, to use only the expenditures associated with this group of persons and not expenditures associated with other individuals in facilities.

(c) *Providing case management services to AIDS patients.*—Allows States to limit the provision of case management services under section 1915(g) to individuals with AIDS or AIDS-related conditions.

Senate amendment

No provision.

Conference agreement

(a) *Eligibility for persons with AIDS-related conditions.*—The conference agreement follows the House provision with a modification providing that eligibility for home and community-based services extends to all individuals who, but for the provision of such services, would require the level of care provided in a hospital, SNF or ICF, the cost of which could be reimbursed under the State Medicaid plan. States are allowed to target their waivers to groups of individuals at risk of hospital care, as defined by illness or diagnosis (e.g., AIDS or AIDS-related condition), or by condition (e.g., chronic mental illness, ventilator dependency).

(b) *Computing expenditures for AIDS patients.*—The conference agreement follows the House bill with a modification allowing States to make their expenditure estimates specific to any group of patients who are in hospitals, SNFs, or ICFs, as defined by illness or diagnosis (e.g., AIDS or AIDS-related condition), or condition (e.g., chronic mental illness, ventilator dependency).

(c) *Provision case management services to AIDS patients.*—The conference agreement follows the House bill.

Effective date.—Applies to applications for waivers (or renewals thereof) approved on or after date of enactment.

10. PERMITTING STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES TO LOW-INCOME INDIVIDUALS WITH CHRONIC MENTAL ILLNESS (SECTION 9411)

Present law

(a) *Eligibility for persons with chronic mental illness.*—Section 1915(c) authorizes the Secretary to waive certain Medicaid requirements to allow States to provide a variety of home and community-

based services to individuals (1) who could otherwise require the level of care provided in a SNF or ICF the cost of which could be reimbursed under the State plan, or (2) who but for the provision of these services would continue to receive inpatient hospital, SNF, or ICF services because they are dependent on ventilator support whose cost is reimbursed under the State plan.

(b) Computing expenditures for patients with chronic mental illness.—In order to receive approval for a waiver, States must provide a number of assurances to the Secretary, including one requiring that the estimated average per capita expenditure for medical assistance under the waiver for those receiving waived services in any fiscal year not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been incurred in that year for that population if the waiver had not been granted.

COBRA allowed States, in estimating average per capita expenditures for waivers applying only to physically disabled individuals in SNFs or ICFs, to use only the expenditures associated with this group of persons and not expenditures associated with other eligible individuals in these facilities.

(c) Providing case management services to patients with chronic mental illness.—Section 1915(g) authorizes the Secretary to provide case management services without regard to requirements that Medicaid services be available throughout a State and that covered services be equal in amount, duration, and scope for certain Medicaid recipients. Case management services are defined as services which will assist individuals eligible under the State's Medicaid plan in gaining access to needed medical, social, educational, and other services.

(d) Expanding services covered under waiver.—Section 1915(c) including among the home and community-based services which may be covered under a waiver the following: case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services as the State may request and the Secretary may approve.

House bill

(a) Eligibility for persons with chronic mental illness.—Extends eligibility for home and community-based services to persons with chronic mental illness who but for the provision of such services would continue to need inpatient hospital care reimbursed under the State plan. Also clarifies with a technical amendment that plan requirements which may be waived under section 1915(c) include comparability of covered services, i.e., that covered services be equal in amount, duration, and scope for certain Medicaid recipients.

(b) Computing expenditures for patients with chronic mental illness.—Allows States, in estimating average per capita expenditures for waivers applying only to persons with chronic mental illness who are in hospitals, SNFs, or ICFs, to use only the expenditures associated with this group of persons and not expenditures associated with other persons in these facilities.

(c) *Providing case management services for patients with chronic mental illness.*—Allows States to limit the provision of case management services under section 1915(g) to individuals with chronic mental illness.

(d) *Expanding services covered under waiver.*—Adds to the list of services which may be offered under a 1915(c) waiver the following: day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.

Senate amendment

No provision.

Conference agreement

(a) *Eligibility for persons with chronic mental illness.*—The conference agreement follows the House bill with a modification providing that eligibility for home and community-based services extends to all individuals who, but for the provision of such services, would require the level of care provided in a hospital, SNF, or ICF, the cost of which could be reimbursed under the State Medicaid plan. States are allowed to target their waivers to groups of individuals at risk of hospital care, as defined by illness or diagnosis (e.g., AIDS or AIDS-related condition), or by condition (e.g., chronic mental illness, ventilator dependency).

(b) *Computing expenditures for patients with chronic mental illness.*—The conference agreement follows the House bill with a modification allowing States to make their expenditure estimates specific to any group of patients in hospitals, SNFs, or ICFs, as defined by illness or diagnosis (e.g., AIDS or AIDS-related condition), or condition (e.g., chronic mental illness, ventilator dependency).

(c) *Providing case management services to patients with chronic mental illness.*—The conference agreement follows the House bill.

(d) *Expanding services covered under waiver.*—The conference agreement follows the House bill.

Effective date.—Applies to applications for waivers (or renewals thereof) approved on or after date of enactment.

11. WAIVER AUTHORITY FOR THE CHRONICALLY MEDICALLY ILL
DEMONSTRATION PROGRAM (SECTION 9412)

Present law

The Robert Wood Johnson Foundation and the Department of Housing and Urban Development (HUD) will jointly fund a 5-year demonstration "Program for the Chronically Mentally Ill." Grants and low-interest loans will be available to eight urban centers with populations in excess of 250,000 to assist in the establishment of a comprehensive system of care and rehabilitation and the expansion of housing options for chronically mentally ill persons. Grantees with approved housing plans will also be eligible for Federal rent subsidy assistance from HUD. HUD will pay the difference between the equivalent of 30 percent of the income of low-income individuals and locally established fair market rents. The Robert Wood Johnson Foundation plans to announce the recipients of grants on November 1, 1986.

House bill

Authorize the Secretary of HHS to waive certain Medicaid requirements to allow States to implement demonstration programs to improve the continuity, quality, and cost-effectiveness of mental health services available to chronically mentally ill Medicaid beneficiaries. Medicaid requirements which may be waived under this program include statewideness, comparability, freedom of choice, review and screening of care, and certain requirements pertaining to entities providing care on a prepaid capitation basis.

Requires that a waiver be granted only if:

(1) the demonstration program is receiving funding from the Robert Wood Johnson Foundation and HUD under the "Program for the Chronically Mentally Ill,"

(2) the State provides assurances to the Secretary of HHS that the estimated average per capita expenditure for medical assistance for mental health provided in any fiscal year to persons covered under the program does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been incurred in that year for such persons if the waiver had not been granted, and

(3) the State assures that there will be no reduction or limitation in benefits to a Medicaid beneficiary under the program.

States may cover the following services under these waivers: case management services for mentally ill patients, habilitation services (as defined in section 1985(c)(5) of Medicaid), day treatment or other partial hospitalization services, residential services (other than room and board), psychosocial rehabilitation services, clinic services (whether or not furnished in a facility), and such other services as the State may request and the Secretary may approve for individuals covered under the demonstration.

Requires that a waiver be granted for an initial term of 3 years and may be extended for an additional 2-years. The request for an extension shall be deemed granted unless the Secretary denies the request in writing within 90 days after submission. The authority for the Secretary of HHS to approve a waiver would extend only during the 5-year period beginning October 1, 1986.

Prohibits the Secretary from requiring, as a condition for approving a waiver, that the actual total expenditures for services provided under the waiver (and the associated claim for Federal matching payments) cannot exceed approved estimates for services. Nor could the Secretary deny Federal matching payments for services on the ground that a State has failed to limit actual total expenditures for services under the waiver to approved estimates for these expenditures.

Requires the Secretary to monitor the implementation of waivers to assure that requirements are met and to terminate any waiver, after notice and opportunity for a hearing, where he or she finds noncompliance has occurred.

Requires the Secretary to report to Congress, not later than Jan. 1, 1993, on the cost, accessibility, utilization, and quality of services provided under these waivers.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with a modification directing the Secretary to grant Medicare and Medicaid waivers in connection with up to 10 projects for the provision of health services to the frail elderly on a risk basis. Section 9220 of P.L. 99-272 required the Secretary to extend Medicare and Medicaid waivers to the On Lok Community Care Organization for Dependent Adults in San Francisco, California. Under the terms of these waivers, On Lok assumes full risk for the provision of comprehensive health services to the frail elderly who are at risk of institutionalization. Capitation payments to On Lok will continue so long as it meets the conditions of its waivers. The Robert Wood Johnson Foundation has provided a grant to On Lok for the purpose of identifying and assisting other community-based organizations develop the ability to provide comprehensive services to frail elderly patients on a risk basis. The Foundation intends to provide financial assistance to this development process.

The conferees wish to learn whether the On Lok approach can be replicated in other areas of the country. The conference agreement therefore requires the Secretary to provide Medicare and Medicaid waivers to up to 10 community-based, public or nonprofit private organizations to enable them to provide health services to frail elderly beneficiaries on a risk basis. The waivers must be granted on the same general terms and conditions as the waivers granted to On Lok, with appropriate adjustments for the phasing in of risk and the circumstances unique to each project. The waivers may be granted only to public or nonprofit private organizations that are community-based and that have been awarded a grant by the Robert Wood Johnson Foundation. The Secretary is not authorized to waive freedom-of-choice protections for either Medicare or Medicaid beneficiaries in connection with these projects.

Effective date.—Enactment.

12. CONTINUATION OF "CASE-MANAGED MEDICAL CARE FOR NURSING HOME PATIENTS" DEMONSTRATION PROJECT (SECTION 9413)

Present law

Section 222 of the Social Security Amendments of 1972, section 402(a) of the Social Security Amendments of 1967, and section 1115 of the Social Security Act provide the Secretary of HHS general authority to conduct experiments and demonstrations on Medicare and Medicaid alternative payment systems and benefits and to waive compliance with various program requirements in conducting these demonstrations. Under this authority, the Secretary has approved Medicare and Medicaid waivers for the demonstration project, "Case-Managed Medical Care for Nursing Home Patients," for the period July, 1983, through July, 1986. These waivers were granted to the Massachusetts Department of Public Welfare to permit fee-for-service reimbursement for the provision of medical services by physician-supervised nurse practitioners/physician assistants for 6,500 residents of nursing homes. Under this demon-

stration, increased medical monitoring is expected to generate cost savings as a result of fewer hospital admissions and hospital outpatient visits. HCFA's Office of Research and Demonstration extended this project through June, 1987.

House bill

Requires the Secretary to approve applications for waivers for continuation of the "Case-Managed Medical Care for Nursing Home Patients" project for the period July 1, 1987, through June 30, 1989, and to continue the approval on the same terms and conditions as applied to the project on July 1, 1986.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

Effective date.—Enactment.

13. HOLDING STATE HARMLESS IN FISCAL YEAR 1987 AGAINST A DECREASE IN THE FEDERAL MEDICAL ASSISTANCE PERCENTAGE (SECTION 9421)

Present law

Section 9528 of COBRA, P.L. 99-272, provided that beginning in fiscal year 1987, the Federal Medical Assistance Percentage (FMAP) is to be calculated on an annual rather than a biennial basis. The FMAP, which represents the Federal share of Medicaid expenditures in the State, is tied to a formula inversely related to the per capita income of the States.

House bill

Provides that the change to the annual calculation shall not apply to a State Medicaid program for calendar quarters occurring in FY 87 if the State would be adversely affected by the change.

Senate amendment

Identical provision.

Conference agreement

The conference agreement follows the Senate amendment.

Effective date.—Effective as though included in COBRA at the time of its enactment.

14. INDEPENDENT QUALITY REVIEW OF HMO SERVICES (SECTION 9431)

Present law

Regulations require that entities which serve Medicaid beneficiaries on a prepayment basis must have internal quality assurance systems meeting certain specifications. Under Medicare, services provided by risk contracting HMOs and CMPs are subject to review by utilization and quality control peer review organizations (PROs) effective January 1, 1987.

House bill

Requires the States to provide for an annual, independent, external review of Medicaid services rendered under prepayment and risk sharing contracts. Such review is to be performed by either a PRO or other private accreditation body. The results of such reviews are to be made available to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

Effective date.—Applies to payments under Title XIX for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out the provision have been promulgated by such date.

15. CLARIFICATION OF FLEXIBILITY IN STATE UTILIZATION REVIEW
SYSTEMS (SECTION 9432)

Present law

States may at their option implement second surgical opinion programs or hospital preadmission review programs. HCFA has proposed a rule which would require every State to have in place by January 1, 1987, a mandatory second surgical opinion program, or as an alternative, an existing utilization review plan that prevents unnecessary surgery, is cost-effective, and meets the Department's approval.

House bill

(a) *Clarification.*—Specifies that nothing in the Medicaid law is to be construed as authorizing the Secretary to require that States operate second surgical opinion programs or inpatient hospital preadmission review programs.

(b) *Report.*—Requires the Secretary to report to Congress not later than January 1, 1992, for each State in a representative sample of States on: (1) the high volume or high cost procedures used by Medicaid patients; (2) payment rates and aggregate spending rates for these procedures; (3) the extent of geographic variation in the rate of performance of such procedures; (4) the rate at which the procedure is performed on Medicaid patients compared to private patients; and (5) the number of physicians willing and qualified to perform second opinions for such procedures. The report is to include: (1) a list of procedures for which the Secretary believes a mandatory second opinion may be appropriate; and (2) an identification of underutilized Medicaid procedures.

Senate amendment

No provisions.

Conference agreement

The conference agreement follows the House bill with the following modifications. The Secretary would be prohibited from publishing interim or final regulations implementing the proposed rule published at 51 Fed. Reg. 21933 (June 17, 1986) until 180 days after submission of a report to the Congress. The report is due by October 1, 1988, but may be submitted earlier; however, implementing regulations may not be published until 180 days after the report has been received by the Congress. The report must provide, for each State in a representative sample of States with mandatory second surgical opinion programs, with hospital preadmission review programs, and with neither programs: (1) a list of high cost and high volume procedures provided under Medicaid; (2) payment rates and aggregate payment amounts for such procedures; (3) the rates at which such procedures are performed on Medicaid patients and, to the extent such data is available to the Secretary from other sources, a comparison of the utilization rates for such procedures among the Medicaid population and among non-Medicaid patients of comparable age; (4) the number of board-certified or board-eligible physicians in the State who serve Medicaid patients and who perform the procedure and, in those States with mandatory second surgical opinion programs, the number of these physicians who provide second opinions; and (5) in the case of States with mandatory second opinion programs or hospital preadmission programs, a description of the extent to which such programs impede access to needed care and the measures which States have taken to reduce these barriers, particularly with respect to Medicaid patients in rural areas. The report must also include a list of the surgical procedures for which the Secretary believes mandatory second opinion programs under Medicaid may be appropriate, according to specified criteria.

The conference agreement also provides that the Secretary submit to the Congress, by January 1, 1990, a study which examines the use of selected high volume or high cost medical treatments and surgical procedures in order to assess their appropriateness, necessity, and effectiveness for Medicaid patients. The study must analyze the extent of significant variation that exists in the rate of performance on Medicaid beneficiaries of selected high volume or high cost treatment procedures and services for small areas within States and among States. The study must also identify underutilized, medically necessary treatments and procedures for which a failure to furnish could have an adverse effect on health status, and the rate of use by Medicaid beneficiaries is significantly less than the rate for comparable, age-adjusted populations. To the extent practicable, the study shall be coordinated with the Medicare patient outcomes research program agreed to by the conferees, particularly with regard to the relationship between geographic variations and patient outcomes.

Effective date.—Enactment.

16. CLARIFICATION OF FLEXIBILITY FOR STATE MEDICAID PAYMENT
SYSTEMS FOR INPATIENT SERVICES (SECTION 9433)

Present law

States are required to provide assurances to the Secretary that their Medicaid payments for hospital, SNF, and ICF services are "reasonable and adequate" to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with State and Federal laws, regulations, and quality and safety standards, and to assure that individuals eligible for medical assistance have reasonable access to inpatient hospital services of adequate quality.

On February 18, 1986, HCFA published a proposed regulation which would limit payments for inpatient hospital services or long-term care facility services to hospitals, SNFs, ICFs, and ICFs/MR to the amount that can reasonably be estimated would have been paid for the services under Medicare reimbursement principles in effect at the time the services were furnished.

House bill

Clarifies that nothing in the Medicaid statute should be construed as authorizing the Secretary to limit the amount of payment that may be made for inpatient hospital services, SNF, or ICF services, including any limitation based on Medicare's reimbursement principles.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with a modification providing that nothing in Title XIX of the Social Security Act shall be construed as authorizing the Secretary to limit the amount of payment adjustments that may be made under a State Medicaid plan with respect to hospitals that serve a disproportionate number of low-income patients with special needs.

Effective date.—As though it were included in P.L. 97-35.

17. FINANCIAL DISCLOSURE REQUIREMENTS FOR HMOs (SECTION 9434)

Present law

(a) *Disclosure of interlocking relationships.*—All entities furnishing services under Medicaid must disclose to the State the identity of each person with a control interest or with an ownership interest of 5 percent or more. In addition, participating providers must disclose, upon request by the State or the Secretary, full and complete information as to the ownership of a subcontractor with whom the entity has had business transactions in excess of \$25,000 per year, and as to any significant business transaction with such subcontractor.

Title XIII of the Public Health Service Act, under which health maintenance organizations (HMOs) may become federally qualified, provides that such plans must report to the Secretary a description of transactions between the HMO and a party in interest, and shall

make such information available to its members upon reasonable request.

(b) *Approval of contractual expenditures.*—Prior to 1983, HCFA regulations required prior approval, by the HCFA regional Medicaid director, of contracts with HMO's exceeding \$100,000.

House bill

(a) *Disclosure of interlocking relationships.*—Requires that each entity that is contracting with a State to provide services to Medicaid beneficiaries on a capitated or risk basis and that is not also a Federally qualified HMO under the Public Health Service Act must report to the State, and on request, to the Secretary, the Inspector General of DHHS, and the Comptroller General, a description of transactions between the entity and parties in interest. Transactions that must be reported include: (i) any sale, exchange, or leasing of property; (ii) any furnishing for consideration of goods, services or facilities (but not salaries paid to employees); and (iii) any loans or extensions of credit. Each organization shall make the information reported available to its enrollees upon reasonable request.

(b) *Approval of contractual expenditures.*—Requires that the Secretary subject to prior review and approval all contracts in excess of \$100,000 between States and entities providing services to Medicaid beneficiaries on a capitated or risk basis.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with a modification providing for the imposition of civil money penalties on entities providing services to Medicaid patients on a risk basis in the following circumstances. If a risk-contracting entity has failed substantially to provide medically necessary items and services that are required (under the State Plan or contract) to be provided to Medicaid-eligible individuals, and if that failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals, then the entity is subject to civil money penalties of up to \$10,000 for each failure. This provision applies to health maintenance organizations, health insuring organizations, or other prepaid health plans contracting with the States on a risk basis under section 1903(m) of the Social Security Act.

The provision is intended to remedy and deter serious failures to abide by acceptable standards of medical practice, rather than isolated cases of inadvertent omissions. The conferees intend that the Secretary, in determining whether and in what amount to apply civil money penalties, take into consideration whether there was a deliberate omission or a pattern of failing to provide necessary items and services, the seriousness of the effect on or risk to patients, and the reasons or circumstances involved. The conferees further expect that the practice standards used to determine that items or services were medically necessary would be based on generally accepted HMO practice standards.

Effective date.—The disclosure requirement is effective 6 months after enactment. The prior approval of contractual expenditures requirement is effective on enactment and applies to contracts entered into, renewed, or extended after the end of the 30-day period beginning on enactment. The civil penalty provision is effective on enactment.

18. DELEGATION TO INSPECTOR GENERAL OF AUTHORITY OVER STATE MEDICAID FRAUD CONTROL UNITS

Present law

Federal administrative responsibility for State Medicaid Fraud Control Units was transferred to the Office of the Inspector General in 1979.

House bill

Directs the Secretary to delegate the authority over State Medicaid Fraud Control Units to the Office of the Inspector General.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

19. COBRA TECHNICAL CORRECTIONS AND CLARIFICATIONS RELATING TO THE MEDICAID PROGRAM (SECTION 9435)

Present law

The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) was signed into law April 7, 1986. COBRA contains a number of technical errors relating to the Medicaid program.

House bill

(a) *Trusts.*—Clarifies that section 9506 of COBRA, regarding the treatment of income from certain trusts, does not apply to such trusts if they were established before April 7, 1986, solely for the benefit of residents in an intermediate care facility for the mentally retarded (ICF/MR).

(b) *Health insuring organizations.*—Clarifies that section 9517(c)(2) of COBRA, regarding the applicability of certain contracting requirements to prepaid plans, shall not apply to the Hartford Health Network, Inc.

(c) *Other technical corrections and clarifications.*—Makes technical corrections and clarifications to COBRA relating to Medicaid errors.

Senate amendment

No provision.

Conference agreement

(a) *Trusts.*—The conference agreement follows the House bill. The conferees emphasize that the rules set forth in section 9506 of COBRA relating to the treatment of certain trust distributions for

purposes of Medicaid eligibility apply only to distributions from grantor trusts, not distributions or principal from non-grantor trusts, such as those established by parents for children.

(b) Health insurance organizations.—The conference agreement does not include the House bill provisions which are included in section 1895(c)(4) of H.R. 3838, the Tax Reform Act of 1986. The conference agreement clarifies that, for purposes of meeting the requirement in section 1903(m)(2)(A)(i) of the Social Security Act, a health insuring organization (HIO) need not be organized under the health maintenance organization laws of a State; instead, the health insuring organization is only required to be organized under the laws of the State in which it is doing business, including a State's corporation law. Thus, an HIO which is organized under the corporation law in the State in which it operates, which makes services accessible as required by section 1903(m)(1)(A)(i), and which has made adequate provision against the risk of insolvency as required by section 1903(m)(1)(A)(ii), has met the requirement of section 1903(m)(2)(A)(i). The HIO need not be organized under the HMO laws of the State in which it operates.

(c) Other technical corrections and clarifications.—The conference agreement does not include the provisions in the House bill that are included in section 1895(c) of H.R. 3838, the Tax Reform Act of 1986. The conference agreement clarifies the rules for payment with respect to an individual who is eligible for both Medicare and Medicaid, who resides in a skilled nursing facility (SNF) or intermediate care facility (ICF), who is having Medicaid payments made on his/her behalf for such institutional services, who has elected Medicare hospice coverage, and who is in a State that has not elected to cover hospice services under its Medicaid program, as allowed by section 9505 of COBRA, P.L. 99-272. In such circumstances, and where the hospice program and the SNF or ICF have entered into a written agreement under which the hospice takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board, the State is directed to pay the hospice program an amount equal to the amounts allocated under the State Medicaid plan for room and board in the SNF or ICF, plus applicable coinsurance amounts. For this purpose, and for purposes of the basic hospice payment provision at section 1902(a)(13)(D), the term "room and board" includes the performance of personal care services that a family caregiver would provide if the individual were at home, including assistance in the activities of daily living (washing and grooming, toileting, dressing, meal service), socializing (companionship, hobbies), administration of medication, maintaining the cleanliness of the resident's bed and room, and supervising and assisting in the use of durable medical equipment and prescribed therapies (such as range of motion exercises, speech and language exercises).

Effective date.—Applies as if included in the enactment of COBRA.

20. PAYMENT FOR CERTAIN LONG-TERM CARE PATIENTS IN HOSPITALS
(SECTION 9436)

Present law

A State may reimburse hospitals for inpatient services rendered to Medicaid-eligible patients who no longer need acute hospital care, who do need a skilled nursing facility (SNF) or intermediate care facility (ICF) level of care, but for whom such services are unavailable due to the shortage of nursing home beds in the community. The rate of payment is the estimated State-wide average rate per patient day for SNF services rather than the hospital's inpatient acute care rate, with one exception. The State may choose to pay the higher inpatient hospital rate for such inappropriately-placed patients if there are no excess beds in the hospital and no excess beds in the region where the hospital is located. Under HCFA regulations, a hospital or region has excess beds if its occupancy rate is under 80 percent.

House bill

Allows the State of New York under its Medicaid plan to pay for services rendered to hospital patients who are awaiting long-term care placement at the higher acute care rate if either the facility or the region has an occupancy rate of 80 percent or more, but only if the Secretary of HHS determines that the State has decertified a sufficient number of hospital beds to offset the additional costs resulting from the higher payment rate.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

Effective date.—Applies to payments for services furnished during the 3-year period beginning Jan. 1, 1986, after the date the Secretary makes the determination described above.

21. RESPIRATORY CARE SERVICES FOR VENTILATOR-DEPENDENT
INDIVIDUALS (SECTION 9408)

Present law

The Medicaid statute makes no direct provision for home respiratory services. A State could, at its option, pay for home respiratory services in any of three ways: (1) as home health care services if the State considers home respiratory services as a medically necessary component of home health care services; (2) as services provided to disabled children under 18, but only if the services cost no more than institutional care and only if all disabled children meeting certain criteria are covered under this optional service; and (3) as home and community-based services under a section 1915(c) waiver.

House bill

No provision.

Senate amendment

Requires States to cover respiratory services in the home for individuals who (1) are medically dependent on a ventilator for life support at least 6 hours per day; (2) have been so dependent for at least 30 consecutive days or the maximum number of days authorized under the State plan, whichever is less, as inpatients; (3) but for home respiratory care, would require respiratory care on an inpatient basis for which Medicaid would pay; (4) have adequate social support services to be cared for at home; and (5) wish to be cared for at home.

Defines respiratory care services as services provided on a part-time basis in the home of the individual by a respiratory therapist or other person skilled in respiratory therapy (determined by the State), payment for which is not otherwise included within other items and services covered for such persons under the State's Medicaid plan. States would not be required to offer respiratory services covered for such persons under the State's Medicaid plan. States would not be required to offer respiratory services of the same amount, duration, and scope to any person except those who meet the above requirements.

Conference agreement

The conference agreement follows the Senate amendment with a modification making the coverage of respiratory care services at home to ventilator-dependent individuals optional with each State.

Effective date.—Applies to services furnished on or after enactment.

22. NEW JERSEY RESPITE CARE PILOT PROGRAM (SECTION 9414)

Present law

Medicaid does not currently cover respite care services except where provided under a home and community-based services waiver approved by the Secretary under section 1915(c).

House bill

No provision.

Senate amendment

Requires the Secretary to enter into an agreement with the State of New Jersey to conduct a pilot project which would provide respite care services to Medicaid-eligible elderly and disabled persons and other elderly and disabled persons for whom respite services are not otherwise reasonably and actually available or provided, and who would be reasonably anticipated to require institutional care without the availability of these services.

Defines respite care services as short-term and intermittent companion or sitter services, homemaker and personal care services, adult day care, inpatient care, and emergency respite as well as peer support and training for family caregivers.

Requires that respite services be available to persons without regard to income (with cost-sharing on a sliding-scale basis related to income), but that priority be given to persons who would be eligible for Medicaid benefits upon institutionalization.

Requires the Secretary to pay New Jersey, in addition to payments the State is otherwise entitled to, an amount equal to 50 percent of the reasonable costs incurred for the project. The Federal payment for the project could not exceed \$1 million for FY 87, and \$2 million for each of the fiscal years 1988 through 1990. The project would have a maximum duration of 4 years, plus an additional period of up to 6 months for final evaluation and reporting.

Requires the Secretary to submit annual reports and a final report. Also requires the Secretary to waive requirements, including formal solicitation and approval requirements, as will further the expeditious and effective implementation of the project.

Conference agreement

The conference agreement follows the Senate amendment with the following modifications. Federal Medicaid matching funds available under the waiver are limited to payment for respite care services to individuals eligible for Medicaid under Title XIX of the Social Security Act, whether or not the State otherwise covered such individuals under its State Plan. The State of New Jersey is required to arrange for an evaluation of the project to be conducted by an entity independent of State government; the results of this evaluation are to be transmitted by the State to the Secretary within 6 months of the termination of the project. The Secretary is directed, upon request by the State, to waive requirements in current Medicaid law relating to statewideness, reimbursement, and comparability; waivers of patient freedom of choice of provider are not authorized.

23. WAIVER OF CERTAIN MEDICAID REQUIREMENTS (SECTION 9422)

Present law

Medicaid law authorizes coverage, for up to three months prior to application, for an individual if such individual: (1) received services during that time period of a type that would be covered under the plan; and (2) would have been eligible for Medicaid at the time the services were received if he or she had applied for Medicaid. South Carolina expanded its Medicaid program in October, 1984, to cover pregnant women with high medical bills. From October, 1984, to July, 1985, the Medical University of South Carolina had served 1,300 patients under the expanded program, but no Medicaid applications had been submitted for the women it served and no Medicaid payment to the University had been made.

Conference agreement

The conference agreement would extend the normal 3-month retroactive coverage period for the Medical University of South Carolina. Medicaid would be allowed to pay for claims for services provided during the period October 1, 1984, to July 1, 1985, to persons who are determined no later than 6 months after the date of enactment to have been eligible when the services were rendered.

Effective date.—Enactment.

MATERNAL AND CHILD HEALTH PROVISIONS

1. AUTHORIZATION OF ADDITIONAL MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT FUNDS (SECTION 9441)

Present law

(a) *Funding level.*—The Deficit Reduction Act of 1984, P.L. 98-369, established a permanent authorization level of \$478 million for the Maternal and Child Health (MCH) Services Block Grant. Under the Balanced Budget and Emergency Deficit Control Act of 1985, P.L. 99-177, MCH Block Grant funds are fully sequesterable, subject to the uniform reduction percentages for nondefense programs.

(b) *Set-aside for special projects.*—Of the amounts appropriated for the MCH Block Grant, the Secretary is directed to use not less than 10 percent and not more than 15 percent for special projects of regional and national significance, including maternal and child health improvement projects, and for research, training, hemophilia, and genetics grants.

House bill

(a) *Additional funds.*—Authorizes appropriations for the MCH Block Grant in the amount of \$553 million for FY 1987, \$557 million for FY 1988, and \$561 million for fiscal years thereafter.

(b) *Set-aside for newborn genetic disorders.*—Requires the Secretary to retain \$7 million in FY 1987, \$7.5 million in FY 1988, and \$8 million in FY 1989 for projects for the screening of newborns for sickle-cell anemia and other genetic disorders. This set-aside is in addition to the existing set-aside for special projects of regional and national significance. The set-aside will sunset after FY 1989 and the funds will become available for allocation to the States.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with a modification to clarify the funding and administrative mechanisms for sickle-cell/newborn genetic screening programs and to establish demonstration programs and projects to help meet the primary and specialized health care needs of children.

The conference agreement provides that of the new amounts authorized and appropriated for the MCH Block Grant, a designated percentage (7% in FY 1987; 8% in FY 1988; and 9% in FY 1989) is to be allocated to the Secretary for projects for the screening of newborns for sickle-cell anemia and other genetic disorders. Project grants are to be selected and administered under the same procedures and practices that are currently in effect with regard to the special projects of regional and national significance that are funded directly by the Secretary. The specific allocation of funds for genetic screening projects is to end in FY 1989, at which time the funds designated for this purpose are to be included within the total amount of funding available to the States for MCH services

and to the Secretary for special projects of regional and national significance.

Of the remaining new amounts authorized and appropriated under the Block Grant, the conference agreement provides that two-thirds of the total is to be allocated in accordance with current law. The remaining one-third of newly authorized and appropriated funds is also to be allocated to the States and to the Secretary in accordance with current law, but must be used by the States and the Secretary for primary and specialized health care services and projects for children. Thus, dedicated funds from the one-third allotment are to be used by the States to develop demonstration programs and projects that provide (1) primary health care services to children, and (2) community-based service networks and case management services for children with special health care needs. Similarly, dedicated funds from the one-third allotment are to be used by the Secretary for special projects of regional and national significance, training, and research that promote access to (1) primary health care services by children, and (2) community-based service networks and case management services for children with special health care needs.

The following example illustrates the Conferees' intended use of the additional funds authorized. Under the conference agreement, the authorization of appropriations for FY 1987 is \$553 million. That represents an increase of \$75 million over both the current authorization and the current appropriations level of \$478 million. If FY 1987 appropriations for the Block Grant are increased by \$75 million over the current level, 7% of that figure, or \$5.25 million, is to be allocated to the Secretary for sickle-cell anemia/genetic screening programs. Of the remaining \$69.75 million of new appropriations for FY 1987, two-thirds, or \$46.50 million, is to be allocated under the requirements of current law which specify how much is to be allocated to the States (85%-90%) and how much is to be allocated to the Secretary (10%-15%). The other one-third, or \$23.25 million also is to be allocated in accordance with the requirements of the current law, that is, 85% to 90% to the States, and 10% to 15% to the Secretary. However, these funds must be used by the States and by the Secretary for primary and specialized health care service programs and projects for children. The Conferees emphasize that these funding allocation rules apply only to the extent that appropriations for the Block Grant exceed the current appropriations level of \$478 million. As explained above, however, the special allocation for sickle-cell anemia/genetic screening programs will no longer be in effect after FY 1989.

It should be noted that in dedicating funds for primary and specialized health services and projects, the Conferees intend that the States and the Secretary support programs that provide individual, personal health care services to children and children with special health care needs. The Conferees have, therefore, included within the conference agreement statutory definitions of the specific types of services that are to be made available through the one-third allotment of dedicated funds.

The Conferees have made no other changes or modifications in the requirements of the MCH Block Grant program with regard to the dedicated funds for primary and specialized health service dem-

onstration programs and projects. Such programs and projects must, therefore, comply with each of the requirements of the MCH Block Grant statute, including those related to planning, non-discrimination, audits, and reports. With regard to mandated reports, however, States must include statistical data and other relevant information concerning these demonstrations on (a) the number and ages of the children served under the demonstrations; (b) the percentage of children assessed who are found to have at least one health condition or problem that requires a referral for additional care; (c) the most common types of health conditions or problems disclosed; (d) the number and location of demonstration service sites as well as a description of demonstration service providers; and (e) the availability of timely follow-up referral care for health conditions or problems that require additional services.

2. MATERNAL AND CHILD HEALTH AND ADOPTION CLEARINGHOUSE (SECTIONS 9442, 9443)

Present law

The Secretary may provide technical assistance to the States to assist them to develop foster care and adoption assistance programs. The Secretary is required periodically to (1) evaluate the foster care, adoption assistance, and child welfare services programs; and (2) collect and publish data pertaining to the incidence and characteristics of foster care and adoptions in the United States.

Each State is required to submit statistical reports as the Secretary may require with respect to children for whom payments are made under the foster care and adoption assistance programs, including information on legal status, demographic characteristics, location, and length of any stay in foster care.

House bill

Requires the Secretary to establish, either directly or by grant or contract, a National Adoption Information Clearinghouse. The Clearinghouse is required to (1) collect, compile, and maintain data and information obtained from studies, research, and reports by public and private agencies, institutions, or individuals concerning all aspects of infant adoption and adoption of children with special needs; (2) compile, maintain, and periodically revise directories of information concerning crisis pregnancy centers, shelters and residences for pregnant women, training programs on adoption, inter-county adoption, statistics on adoption, and any other information relating to adoption (for pregnant women, infertile couples, adoptive parents, unmarried individuals who want to adopt children, individuals who have been adopted, birth parents who have placed a child for adoption, adoption agencies, social workers, counselors, or other individuals who work in the adoption field); and (3) disseminate the most current and complete information regarding adoption, including directories compiled, maintained, and revised pursuant to (2) above.

Conference agreement

The conference agreement follows the House bill with a modification to clarify the functions of the National Adoption Information Clearinghouse and to require the Secretary of HHS to develop a system for the uniform collection of data on adoption and foster care services in the United States.

Under the conference agreement, the National Adoption Information Clearinghouse is designed to serve two purposes: (1) to facilitate the identification and dissemination of available research, studies, and reports on infant adoption and adoption of children with special needs; and (2) to provide for the development and dissemination of directories of information regarding various aspects of adoption as specified in the conference agreement. Thus, the function of the Clearinghouse is simply to provide easy access to information that has already been developed, collected, and prepared on adoption services and programs. The Clearinghouse is not authorized to conduct research or gather statistical data on issues concerning adoption and foster care; rather it is only authorized to disseminate such research and data as it becomes available to all those who voluntarily seek this information.

The conference agreement also requires the Secretary of HHS to create an advisory committee to identify the national needs for data relating to adoption and foster care and to evaluate alternative ways of collecting such data on a comprehensive basis. By July 1988, the Secretary is required to report to Congress on a proposed data collection system. Final regulations providing for the implementation of such a system are to be promulgated by January 1, 1989 with full implementation to take place no later than October 1, 1991. Information gathered through the data collection system is to be disseminated as it becomes available through the National Adoption Information Clearinghouse (described above).

Effective date.—Enactment.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 9, 1986.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce,
U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached estimate of the budget impact of the reconciliation provisions within the jurisdiction of subconference 21.

If you wish further details on these estimates, we will be pleased to provide them.

With best wishes,
Sincerely,

RUDOLPH G. PENNER, *Director.*

ESTIMATED BUDGET IMPACT OF RECONCILIATION PROVISIONS—SUBCONFERENCE 21: MEDICAID AND MATERNAL AND CHILD HEALTH

[By fiscal year, in millions of dollars]

Section provision	Change from Gradison base 1987	Change from adjusted reconciliation baseline		
		1987	1988	1989
DIRECT SPENDING—MEDICAID				
9401—Optional Coverage of Poor Pregnant Women and Children:				
Budget authority	25	25	85	110
Outlay	25	25	85	110
9402—Optional Coverage of Elderly and Disabled Poor:				
Budget authority	30	30	100	140
Outlay	30	30	100	140
9403—Optional Coverage of Poor Medicare Beneficiaries for Cost Sharing Expenses:				
Budget authority	15	15	70	100
Outlay	15	15	70	100
9404—Medicaid Eligibility for Qualified Severely Impaired:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
9405—Clarification of Eligibility for Homeless:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
9406—Payment for Aliens Under Medicaid:				
Budget authority	45	45	135	165
Outlay	45	45	135	165
9407—Optional Presumptive Eligibility Period for Pregnant Women:				
Budget authority	2	2	2	2
Outlay	2	2	2	2
9408—Optional Respiratory Care for Ventilator Dependents:				
Budget authority	(¹)	(¹)	(¹)	(¹)
Outlay	(¹)	(¹)	(¹)	(¹)
9411—Permitting States to Offer Home and Community Based Services to Certain Persons:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
9412—Waiver Authority for Mentally ill and Frail Elderly:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
9413—Continuation of Case Managed Nursing Home Demonstration:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
9414—N.J. Respite Care Project:				
Budget authority	1	1	2	2
Outlay	1	1	2	2
9415—Inapplicability of Paperwork Reduction Act:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
9421—Hold States Harmless Against a Decrease in Match Rate:				
Budget authority	50	50	0	0
Outlay	50	50	0	0
9422—Waiver of Certain Requirements:				
Budget authority	2	2	0	0
Outlay	2	2	0	0
9431—Independent Quality Review of HMO Services:				
Budget authority	(¹)	(¹)	(¹)	(¹)
Outlay	(¹)	(¹)	(¹)	(¹)
9432—Moratorium on Promulgation of Certain Regulations:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
9433—Flexibility in State Medicaid Payment Systems:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
9434—Financial Disclosure Requirements for HMOs:				
Budget authority	0	0	0	0

ESTIMATED BUDGET IMPACT OF RECONCILIATION PROVISIONS—SUBCONFERENCE 21: MEDICAID AND MATERNAL AND CHILD HEALTH—Continued

[By fiscal year, in millions of dollars]

Section provision	Change from Gradison base 1987	Change from adjusted reconciliation baseline		
		1987	1988	1989
Outlay	0	0	0	0
9435—COBRA Technical Corrections and Clarifications:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
4936—Payment of Certain Long Term Patients in Hospitals:				
Budget authority	0	0	0	0
Outlay	0	0	0	0
Total—Medicaid:				
Budget authority	170	170	394	519
Outlay	170	170	394	519
AUTHORIZATIONS—MATERNAL AND CHILD HEALTH				
9441—Authorization for MCH Services Block Grant Funds:				
Budget authority	75	75	79	83
Outlay	42	42	68	78
9442—MCH Adoption Clearinghouse:				
Budget authority	(¹)	(¹)	(¹)	(¹)
Outlay	(¹)	(¹)	(¹)	(¹)
9443—Collection of Data Relating to Adoption and Foster Care:				
Budget authority	(¹)	(¹)	0	0
Outlay	(¹)	(¹)	0	0
Total—MCH:				
Budget authority	75	75	79	83
Outlay	42	42	68	78
Total—Subconference 21:				
Budget authority	245	245	473	602
Outlay	212	212	462	597

¹ Means less than \$500,000.

From the Committee on the Budget, for consideration of the entire House bill and Senate amendment, except for revenue measures on which conferees from the Committee on Ways and Means have been appointed:

WILLIAM H. GRAY III,
MIKE LOWRY,
BUTLER DERRICK,
ED JENKINS,
CHET ATKINS

(for purposes of short title/
table of contents, title VII,
and section 6004 only),

DELBERT L. LATTI,
LYNN MARTIN,

From the Committee on the Budget, solely for consideration of those portions of the House bill and Senate amendment, continuing revenue measures on which conferees from the Committee on Ways and Means have been appointed:

ED JENKINS,

Finder's Aid
P.L. 99-514 (100 Stat. 2085) Approved October 22, 1986
Tax Reform Act of 1986

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-426</u>	<u>S.Rep. 99-313</u>	<u>H.C.Rep.* 99-841</u>
Redesignation of Internal Revenue Code of 1954 to Internal Revenue Code of 1986	201(a)(3)	2	2095	78	—	II 837
Old-Age and Survivors Insurance - Husband's Benefits (technical correction)	202(c)(5)(B)	1883(a)(1)	2916	—	1073	II 841 II 854
Old-Age and Survivors Insurance - Reduction of Benefits (technical correction)	202(q)(5)(A) (1)	1883(a)(2)	2916	—	1073	II 841 II 854
Old-Age and Survivors Insurance - Reduction of Benefits (technical correction)	202(q)(5)(C)	1883(a)(3)	2916	—	1073	II 841 II 854
Definition of Wages - Exclusions - Cafeteria Plans (technical amendment)	209(e)(8)	1151(d)(2) (C)	2505	—	—	—
Definition of Wages - Exclusions - Cafeteria Plans (conforming amendment)	209(e)(9) New	1151(d)(2) (C)	2505	—	—	II 542
Definitions of Wages - Exclusions - Prizes and Awards (conforming amendment)	209(s)	122(c)(5)	2112	6, 103	47	II 17

* The text contained in Volume I of the Conference Report is essentially the same as the Act as finally approved and thus is not duplicated here.

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-426</u>	<u>S.Rep. 99-313</u>	<u>H.C.Rep. 99-841</u>
Definition of Employment - Federal Legislative Branch (technical correction)	210(a)(5)(G)	1883(a)(4)	2916	—	1073	II 841 II 854
Definition of Employment - Medicare Qualified Government Employment - Election Workers (technical amendment)	210(p)(2)(C)	1895(b)(18) (B)(1)	2935	—	—	II 841 II 860
Definition of Employment - Medicare Qualified Government Employment - Election Workers (technical amendment)	210(p)(2)(D)	1895(b)(18) (B)(ii)	2935	—	—	II 841 II 860
Definition of Employment - Medicare Qualified Government Employment - Election Workers	210(p)(2)(E) New	1895(b)(18) (B)(iii)	2935	—	—	II 841 II 860
Definition of Employment - Medicare Qualified Government Employment (technical correction)	210(p)(4)(B)	1895(b)(19)	2935	—	—	II 841 II 860
Self-Employment - Church Employee Income (conforming amendment)	211(a)(13)	1882(b)(2) (B)(i)	2915	1041	1071	II 841 II 833
Self-Employment - Church Employee Income (conforming amendment)	211(b)	1882(b)(2) (B)(ii)	2915	1041	1071	II 841
Self-Employment - Church Employee Income (technical correction)	211(c)(2)(G)	1883(a)(6)	2916	—	1073	II 841 II 833
Self-Employment - Church Employee Income - No Deduction - Separate from Other Net Earnings	211(i) New	1882(b)(2) (A)	2915	1042	1071	II 841 II 853
Computation of Primary Insurance Amount - Cost-of-Living Increase (technical correction)	215(i)(5)(B) (ii)	1883(a)(7) (A)	2916	—	1073	II 841 II 854

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-426</u>	<u>S.Rep. 99-313</u>	<u>H.C.Rep. 99-841</u>
Computation of Primary Insurance Amount - Cost-of-Living Increase (technical correction)	215(i)(5)(B)	1883(a)(7)(B)	2916	--	1073	II 841, II 854
State and Local Coverage - Wisconsin Retirement Fund (technical correction)	218(m) Heading	1883(a)(8)	2916	--	1073	II 841 II 854
Disability Determinations - State Reimbursement (technical correction)	221(e)	1883(a)(9)	2916	--	1073	II 841 II 854
Disability Insurance Benefits - Payment Pending Appeal (technical correction)	223(g)(1)	1883(a)(10)	2916	--	1073	II 841 II 854
AFDC - State Plans - Report of Income and Resources (technical correction)	402(a)(14)	1883(a)(5)(B)	2916	--	1073	II 841 II 854
AFDC - State Plans - Determining Income and Resources - Step Parent	402(a)(31)(A)	1883(b)(1)(A)	2917	--	1074	II 841 II 854
AFDC - State Plans - Income and Resources - Home Energy Grants (technical correction)	402(a)(36)	1883(b)(4)(B)	2917	--	1073	II 841 II 854
AFDC - State Plans - Medicaid Eligibility After Termination (technical correction)	402(a)(37)	1883(b)(4)(A)	2917	--	1073	II 841 II 854
AFDC - State Plans - Income and Resources - Parents and Siblings (technical correction)	402(a)(38)	1883(b)(2)(B)	2917	--	1074	II 841 II 854
AFDC - State Plans - Income and Resources - Parents and Siblings (technical correction)	402(a)(38)	1883(b)(4)(A)	2917	--	1074	II 841 II 854
AFDC - State Plans - Income and Resources - Parents and Siblings (technical correction)	402(a)(38)	1883(b)(2)(A)	2917	--	1074	II 841 II 854

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-426</u>	<u>S.Rep. 99-313</u>	<u>H.C.Rep. 99-841</u>
AFDC - State Plans - Age of Minor Parents (technical correction)	402(a)(39)	1883(b)(3) (A)	2917	--	1075	II 841 II 854
AFDC - State Plans - Income and Resources of Minor Parents (technical correction)	402(a)(39)	1883(b)(4) (A)	2917	--	1075	II 841 II 854
AFDC - State Plans - Compatibility with Food Stamp Program (technical correction)	402(a)	1883(b)(5)	2917	--	1073	II 841 II 854
AFDC - State Plans - Redesignation of Internal Revenue Code of 1954 to 1986 (conforming amendment)	402(d)(1)	2	2095	--	--	II 837
Child Support - Administrative Order (conforming amendment)	457(b)(3)	1899(a)	2957	--	1078	II 841 II 854
Child Support - State Collection (technical correction)	457(c)	1883(b)(6)	2917	--	--	II 841 II 854
Child Support - Collection by One State for Another - Incentive Payments (technical correction)	458(d)	1883(b)(7)	2917	1047	1076	II 841 II 854
Child Support - Tax Refunds (technical correction)	464(b)(2)(A)	1883(b)(8)	2917	--	1073	II 841 II 854
Foster Care and Adoption Assistance - Adoption Expenses - Children With Special Needs (conforming amendment)	470	1711(c)(1)	2784	52, 875	--	--
Foster Care and Adoption Assistance - Adoption Expenses - Children With Special Needs (conforming amendment)	471(a)(1)	1711(c)(2)	2784	52, 875	--	--

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-426</u>	<u>S.Rep. 99-313</u>	<u>H.C.Rep. 99-841</u>
Foster Care and Adoption Assistance - Adoption Expenses - Children With Special Needs (conforming amendment)	471(a)(11)	1711(c)(2)	2784	52, 875	--	--
Foster Care and Adoption Assistance - Adoption Expenses - Children With Special Needs	473(a)(1)	1711(a)(2)	2783	52, 875	--	--
Foster Care and Adoption Assistance - Adoption Expenses - Children With Special Needs (technical amendment)	473(a)(2) Redesig- nated as 473(a)(3)	1711(a)(1)	2783	--	--	--
Foster Care and Adoption Assistance - Adoption Expenses - Children With Special Needs (conforming amendment)	473(a)(3)	1711(c)(3) (A)	2784	52, 875	--	--
Foster Care and Adoption Assistance - Adoption Expenses - Children With Special Needs (conforming amendment)	473(a)(3)	1711(c)(3) (B)	2784	52, 875	--	--
Foster Care and Adoption Assistance - Adoption Expenses - Children With Special Needs (technical amendment)	473(a)(3) Redesig- nated as 473(a)(4)	1711(a)(1)	2783	--	--	--
Foster Care and Adoption Assistance - Adoption Expenses - Children With Special Needs (technical amendment)	473(a)(4) Redesig- nated as 473(a)(5)	1711(a)(1)	2783	--	--	--
Foster Care and Adoption Assistance - Assistance During Period of Placement Under State and Local Laws (conforming amendment)	473(a)(5)	1711(c)(4)	2784	52, 875	--	--

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-426</u>	<u>S.Rep. 99-313</u>	<u>H.C.Rep. 99-841</u>
Foster Care and Adoption Assistance - Children With Special Needs - Definition of "Nonrecurring Adoption Assistance"	473(a)(6) New	1711(b)	2783	--	--	--
Foster Care and Adoption Assistance - Adoption Expenses - Children With Special Needs (conforming amendment)	473(b)(1)(A)	1711(c)(5)	2784	52, 875	--	--
Foster Care and Adoption Assistance - Payment to States (technical correction)	474(a)	1883(b)(9)	2917	--	1073	II 841 II 854
Foster Care and Adoption Assistance - Children With Special Needs - Definition of "Adoption Assistance Agreement" (conforming amendment)	475(3)(A)	1711(c)(6)	2783	--	--	--
Foster Care and Adoption Assistance - Exclusion of Foster Care Assistance Recipient from AFDC Unit	478 New	1883(b)(10) (A)	2917	--	1076	II 841 II 854
General Provisions - Definition of "Person" (technical correction)	1101(a)(3)	1883(c)(1)	2918	--	1073	II 841 II 854
General Provisions - Definition of "Corporation" (technical correction)	1101(a)(4)	1883(c)(1)	2918	--	1073	II 841 II 854
General Provisions - Definition of "Shareholders" (technical correction)	1101(a)(5)	1883(c)(1)	2918	--	1073	II 841 II 854
General Provisions - Pilot Project for Integrated Service Delivery (technical correction)	1136(b)(7)	1883(c)(2)	2918	--	1073	II 841 II 854

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-426</u>	<u>S.Rep. 99-313</u>	<u>H.C.Rep. 99-841</u>
Health Care Peer Review - 100% Review of Certain Surgical Procedures (technical correction)	1164(b)(4) (B)	1895(b)(17)	2934	—	—	II 841 II 854
Supplemental Security Income - Meaning of Income (technical correction)	1612(a)(1)(C)	1883(d)(2)	2918	—	1073	II 841 II 854
Supplemental Security Income - Exclusions from Income (technical correction)	1612(b)(2)(A)	1883(d)(3) (A)	2918	—	1073	II 841 II 854
Supplemental Security Income - Exclusions from Income (technical correction)	1612(b)(2)(B)	1883(d)(3) (B)	2918	—	1073	II 841 II 854
Supplemental Security Income - Exclusions from Income (technical correction)	1612(b)(11)	1883(d)(3) (C)	2918	—	1073	II 841 II 854
Supplemental Security Income - Exclusions from Income (technical correction)	1612(b)(12)	1883(d)(3) (C)	2918	—	1073	II 841 II 854
Supplemental Security Income - Exclusions from Income (technical correction)	1612(b)(13)	1883(d)(3) (C)	2918	—	1073	II 841 II 854
Supplemental Security Income - State Interim Assistance Payments Reimbursement (technical correction)	1631(g) Heading	1883(d)(1)	2918	—	1073	II 841 II 854
Medicare - Enrollment Periods (technical correction)	1837(i)(1)(A)	1895(b)(12)	2934	1044	—	II 841 II 860
Medicare - Contracts With Carriers - Physician Payment (technical correction)	1842(b)(4)(C) (i)	1895(b)(14) (A)(ii)	2934	—	1113	II 841 II 860

P.L. 99-514 (Cont.)

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-426</u>	<u>S.Rep. 99-313</u>	<u>H.C.Rep. 99-841</u>
Medicare - Contracts With Carriers - Physician Payment (technical amendment)	1842(b)(4)(C) (ii) Stricken	1895(b)(14) (A)(i)	2934	--	--	--
Medicare - Directories of Participating Physicians (technical correction)	1842(h)(5)	1895(b)(15) (A)	2934	--	1113	II 841 II 860
Medicare - Directories of Participating Physicians (technical correction)	1842(h)(6)	1895(b)(15) (B)	2934	--	1113	II 841 II 860
Medicare - Fraudulent Billing for Assistant in Cataract Surgery (technical correction)	1842(k)	1895(b)(16) (A)	2934	--	1113	II 841 II 860
Medicare - Agreements with Providers (technical correction)	1866(a)(1)(I)	1895(b)(5) (A)	2933	--	1113	II 841 II 860
Medicare - Agreements with Providers (technical correction)	1866(a)(1)(I) [Duplicate designation added by P.L. 99-272] Redesig- nated as (k)	1895(b)(5) (C)	2933	--	1113	II 841 II 860
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Public Law 99-514
99th Congress

An Act

To reform the internal revenue laws of the United States.

Oct. 22, 1986

[H.R. 3838]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Tax Reform Act
of 1986.
26 USC 1 *et seq.*

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- Sec. 1502. Increase in penalty for failure to pay tax.
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- Sec. 1511. Differential interest rate.
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Subtitle C—Information Reporting Provisions

- Sec. 1521. Requirement of reporting for real estate transactions.
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Subtitle D—Provisions Relating to Tax Shelters

- Sec. 1531. Modification of tax shelter ratio test for registration of tax shelters.
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- Sec. 1534. Increased penalty for failure to maintain lists of investors in potentially abusive tax shelters.
- Sec. 1535. Clarification of treatment of sham or fraudulent transactions under section 6621(c).

Subtitle E—Estimated Tax Provisions

- Sec. 1541. Current year liability test increased from 80 to 90 percent for estimated tax payments by individuals.
- Sec. 1542. Certain tax-exempt organizations subject to corporate estimated tax rules.
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- Sec. 1551. Limitations on awarding of court costs and certain fees modified.
- Sec. 1552. Failure to pursue administrative remedies.
- Sec. 1553. Tax Court practice fee.
- Sec. 1554. Clarification of jurisdiction over addition to tax for failure to pay amount of tax shown on return.
- Sec. 1555. Authority to require attendance of United States marshals at Tax Court sessions.
- Sec. 1556. Changes in certain provisions relating to special trial judges.
- Sec. 1557. Effect on retired pay by election to practice law, etc., after retirement.
- Sec. 1558. Authorization for appeals from interlocutory orders of the Tax Court.
- Sec. 1559. Changes relating to annuities for surviving spouses and dependent children of Tax Court judges.

Subtitle G—Tax Administration Provisions

- Sec. 1561. Suspension of statute of limitations if third-party records not produced within 6 months after service of summons.
- Sec. 1562. Authority to rescind notice of deficiency with taxpayer's consent.

- Sec. 1563. Authority to abate interest due to errors or delays by the Internal Revenue Service.
- Sec. 1564. Suspension of compounding where interest on deficiency suspended.
- Sec. 1565. Certain service-connected disability payments exempt from levy.
- Sec. 1566. Increase in value of personal property subject to certain listing and notice procedures.
- Sec. 1567. Certain recordkeeping requirements.
- Sec. 1568. Disclosure of returns and return information to certain cities.
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Subtitle H—Miscellaneous Provisions

- Sec. 1571. Withholding allowances to reflect new rate schedules.
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TITLE XVI—EXEMPT AND NONPROFIT ORGANIZATIONS

- Sec. 1601. Certain distributions of low cost articles and exchanges and rentals of member lists by certain organizations not to be treated as unrelated trade or business.
- Sec. 1602. Educational activities at convention and trade shows.
- Sec. 1603. Tax exemption for certain title-holding companies.
- Sec. 1604. Exception to membership organization deduction rules.
- Sec. 1605. Tax-exempt status for an organization introducing into public use technology developed by qualified organizations.
- Sec. 1606. Definition of government official.
- Sec. 1607. Transition rule for acquisition indebtedness with respect to certain land.
- Sec. 1608. Treatment of certain amounts paid to or for the benefit of certain institutions of higher education.

TITLE XVII—MISCELLANEOUS PROVISIONS

- Sec. 1701. Extension and modification of targeted jobs credit.
- Sec. 1702. Certain diesel fuel taxes may be imposed on sales to retailers.
- Sec. 1703. Gasoline tax generally collected at terminal level.
- Sec. 1704. Exemption from social security coverage for certain clergy.
- Sec. 1705. Applicability of unemployment compensation tax to certain services performed for certain Indian tribal governments.
- Sec. 1706. Treatment of certain technical personnel.
- Sec. 1707. Exclusion for certain foster care payments.
- Sec. 1708. Extension of rules for spouses of individuals missing in action.
- Sec. 1709. Amendment to the Reindeer Industry Act of 1937.
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- Sec. 1711. Adoption assistance agreements under adoption assistance program: payment of nonrecurring expenses related to adoptions of children with special needs.

TITLE XVIII—TECHNICAL CORRECTIONS

- Sec. 1800. Coordination with other titles.

Subtitle A—Amendments Related to the Tax Reform Act of 1984

CHAPTER 1—AMENDMENTS RELATED TO TITLE I OF THE ACT

- Sec. 1801. Amendments related to deferral of certain tax reductions.
- Sec. 1802. Amendments related to tax-exempt entity leasing provisions.
- Sec. 1803. Amendments related to treatment of bonds and other debt instruments.
- Sec. 1804. Amendments related to corporate provisions.
- Sec. 1805. Amendments related to partnership provisions.
- Sec. 1806. Amendments related to trust provisions.
- Sec. 1807. Amendments related to accounting changes.
- Sec. 1808. Amendments related to tax straddle provisions.
- Sec. 1809. Amendments related to depreciation provisions.
- Sec. 1810. Amendments related to foreign provisions.
- Sec. 1811. Amendments related to reporting, penalty, and other provisions.
- Sec. 1812. Amendments related to miscellaneous provisions.

CHAPTER 2—AMENDMENTS RELATED TO TITLE II OF THE ACT

- Sec. 1821. Amendments related to section 211 of the Act.
- Sec. 1822. Amendments related to section 216 of the Act.
- Sec. 1823. Amendment related to section 217 of the Act.
- Sec. 1824. Amendment related to section 218 of the Act.
- Sec. 1825. Amendments related to section 221 of the Act.
- Sec. 1826. Amendments related to section 222 of the Act.

- Sec. 1827. Amendments related to section 223 of the Act.
- Sec. 1828. Amendment related to section 224 of the Act.
- Sec. 1829. Waiver of interest on certain underpayments of tax.
- Sec. 1830. Scope of section 255 of the Tax Equity and Fiscal Responsibility Act of 1982.

CHAPTER 3—AMENDMENTS RELATED TO TITLE III OF THE ACT

- Sec. 1831. Amendment related to section 301 of the Act.
- Sec. 1832. Amendment related to section 303 of the Act.
- Sec. 1833. Amendment related to section 305 of the Act.
- Sec. 1834. Amendment related to section 311 of the Act.

CHAPTER 4—AMENDMENTS RELATED TO TITLE IV OF THE ACT

- Sec. 1841. Amendment related to section 311 of the Act.
- Sec. 1842. Amendments related to section 421 of the Act.
- Sec. 1843. Amendments related to section 422 of the Act.
- Sec. 1844. Amendments related to section 431 of the Act.
- Sec. 1845. Amendment related to section 452 of the Act.
- Sec. 1846. Amendments related to section 473 of the Act.
- Sec. 1847. Amendments related to section 474 of the Act.
- Sec. 1848. Amendments related to section 491 of the Act.

CHAPTER 5—AMENDMENTS RELATED TO SECTION 216 OF THE ACT

- Sec. 1851. Amendments related to welfare benefit plan provisions.
- Sec. 1852. Amendments related to pension plan provisions.
- Sec. 1853. Amendments related to fringe benefit provisions.
- Sec. 1854. Amendments related to employee stock ownership plans.
- Sec. 1855. Amendments related to miscellaneous employee benefit provisions.

CHAPTER 6—AMENDMENTS RELATED TO TITLE VI OF THE ACT

- Sec. 1861. Amendments related to section 611 of the Act.
- Sec. 1862. Amendment related to section 612 of the Act.
- Sec. 1863. Amendment related to section 613 of the Act.
- Sec. 1864. Amendments related to section 621 of the Act.
- Sec. 1865. Amendment related to section 622 of the Act.
- Sec. 1866. Transitional rule for limit on small issue exception.
- Sec. 1867. Amendments related to section 624 of the Act.
- Sec. 1868. Amendment related to section 625 of the Act.
- Sec. 1869. Amendments related to section 626 of the Act.
- Sec. 1870. Amendment related to section 627 of the Act.
- Sec. 1871. Amendments related to section 628 of the Act.
- Sec. 1872. Amendments related to section 631 of the Act.
- Sec. 1873. Amendments related to section 632 of the Act.

CHAPTER 7—MISCELLANEOUS PROVISIONS

- Sec. 1875. Amendments related to title VII of the Act.
- Sec. 1876. Amendments related to title VIII of the Act.
- Sec. 1877. Amendments related to title IX of the Act.
- Sec. 1878. Amendments related to title X of the Act.
- Sec. 1879. Miscellaneous provisions.

CHAPTER 8—EFFECTIVE DATE

- Sec. 1881. Effective date.

Subtitle B—Related to Other Programs Affected by the Deficit Reduction Act of 1984

CHAPTER 1—AMENDMENTS RELATED TO SOCIAL SECURITY ACT PROGRAMS

- Sec. 1882. Amendments related to coverage of church employees (section 2603 of the Deficit Reduction Act).
- Sec. 1883. Technical corrections in other provisions related to Social Security Act programs.

CHAPTER 2—AMENDMENTS RELATED TO UNEMPLOYMENT COMPENSATION PROGRAM

- Sec. 1884. Technical corrections in Federal Unemployment Tax Act.

CHAPTER 3—AMENDMENTS RELATED TO TRADE AND TARIFF PROGRAMS

- Sec. 1885. Amendments to the tariff schedules.
- Sec. 1886. Technical corrections to countervailing and antidumping duty provisions.

- Sec. 1887. Amendments to the Trade Act of 1974.
- Sec. 1888. Amendments to the Tariff Act of 1930.
- Sec. 1890. Amendments to the Caribbean Basin Economic Recovery Act.
- Sec. 1891. Conforming amendments regarding customs brokers.
- Sec. 1892. Special effective date provisions for certain articles given duty-free treatment under the Trade and Tariff Act of 1984.
- Sec. 1893. Technical amendments relating to customs user fees.

Subtitle C—Miscellaneous

CHAPTER 1—AMENDMENTS RELATED TO THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

- Sec. 1895. COBRA technical corrections relating to Social Security Act programs.
- Sec. 1896. Extension of time for filing for credit or refund with respect to certain changes involving insolvent farmers.
- Sec. 1897. Correction of clerical error in amendments to coal tax.

CHAPTER 2—AMENDMENTS RELATED TO THE RETIREMENT EQUITY ACT OF 1984

- Sec. 1898. Technical corrections to the Retirement Equity Act of 1984.

CHAPTER 3—AMENDMENT RELATED TO THE CHILD SUPPORT ENFORCEMENT AMENDMENTS OF 1984

- Sec. 1899. Amendment related to the Child Support Enforcement Amendments of 1984.

CHAPTER 4—MISCELLANEOUS AMENDMENTS CORRECTING ERRORS OF SPELLING, PUNCTUATION, ETC.

- Sec. 1899A. Miscellaneous amendments correcting errors of spelling, punctuation, etc.

SEC. 2. INTERNAL REVENUE CODE OF 1986.

(a) **REDESIGNATION OF 1954 CODE.**—The Internal Revenue Title enacted August 16, 1954, as heretofore, hereby, or hereafter amended, may be cited as the “Internal Revenue Code of 1986”.

(b) **REFERENCES IN LAWS, ETC.**—Except when inappropriate, any reference in any law, Executive order, or other document—

(1) to the Internal Revenue Code of 1954 shall include a reference to the Internal Revenue Code of 1986, and

(2) to the Internal Revenue Code of 1986 shall include a reference to the provisions of law formerly known as the Internal Revenue Code of 1954.

SEC. 3. AMENDMENT OF 1986 CODE; COORDINATION WITH SECTION 15.

(a) **AMENDMENT OF 1986 CODE.**—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

(b) **COORDINATION WITH SECTION 15.**—

(1) **IN GENERAL.**—Except as provided in paragraph (2), for purposes of section 15 of the Internal Revenue Code of 1986, no amendment or repeal made by this Act shall be treated as a change in the rate of a tax imposed by chapter 1 of such Code.

(2) **EXCEPTION.**—Paragraph (1) shall not apply to the amendment made by section 601 (relating to corporate rate reductions).

and possessions of the United States, to the extent allowed by section 901, only in respect of so much of the taxes described in such section as is not properly allocable under such section to the beneficiaries."

(3) Paragraph (3) of section 901(i) (relating to cross references) is amended by striking out "section 642(a)(1)" and inserting in lieu thereof "section 642(a)".

(4) Paragraph (6) of section 7871(a) (relating to Indian tribal governments treated as States for certain purposes) is amended by striking out subparagraph (A) and by redesignating subparagraphs (B), (C), (D), (E), and (F) as subparagraphs (A), (B), (C), (D), and (E), respectively.

(5) The table of sections for subpart A of part IV of subchapter A of chapter 1 is amended by striking out the item relating to section 24.

Subtitle C—Provisions Related to Exclusions

SEC. 121. TAXATION OF UNEMPLOYMENT COMPENSATION.

Section 85 (relating to unemployment compensation) is amended to read as follows:

"SEC. 85. UNEMPLOYMENT COMPENSATION.

"(a) **GENERAL RULE.**—In the case of an individual, gross income includes unemployment compensation.

"(b) **UNEMPLOYMENT COMPENSATION DEFINED.**—For purposes of this section, the term 'unemployment compensation' means any amount received under a law of the United States or of a State which is in the nature of unemployment compensation."

SEC. 122. PRIZES AND AWARDS.

(a) **EXCLUSION FROM GROSS INCOME.**—

(1) **IN GENERAL.**—Section 74 (relating to prizes and awards) is amended—

(A) by striking out "Except as provided in subsection (b) and" in subsection (a) and inserting in lieu thereof "Except as otherwise provided in this section or",

(B) by striking out "EXCEPTION" in the heading for subsection (b) and inserting in lieu thereof "EXCEPTION FOR CERTAIN PRIZES AND AWARDS TRANSFERRED TO CHARITIES",

(C) by striking out "and" at the end of subsection (b)(1), by striking out the period at the end of subsection (b)(2) and inserting in lieu thereof "; and", and by adding after subsection (b)(2) the following new paragraph:

"(3) the prize or award is transferred by the payor to a governmental unit or organization described in paragraph (1) or (2) of section 170(c) pursuant to a designation made by the recipient.", and

(D) by adding at the end thereof the following new subsection:

"(c) **EXCEPTION FOR CERTAIN EMPLOYEE ACHIEVEMENT AWARDS.**—

"(1) **IN GENERAL.**—Gross income shall not include the value of an employee achievement award (as defined in section 274(j)) received by the taxpayer if the cost to the employer of the employee achievement award does not exceed the amount

allowable as a deduction to the employer for the cost of the employee achievement award.

“(2) **EXCESS DEDUCTION AWARD.**—If the cost to the employer of the employee achievement award received by the taxpayer exceeds the amount allowable as a deduction to the employer, then gross income includes the greater of—

“(A) an amount equal to the portion of the cost to the employer of the award that is not allowable as a deduction to the employer (but not in excess of the value of the award), or

“(B) the amount by which the value of the award exceeds the amount allowable as a deduction to the employer. The remaining portion of the value of such award shall not be included in the gross income of the recipient.

“(3) **TREATMENT OF TAX-EXEMPT EMPLOYERS.**—In the case of an employer exempt from taxation under this subtitle, any reference in this subsection to the amount allowable as a deduction to the employer shall be treated as a reference to the amount which would be allowable as a deduction to the employer if the employer were not exempt from taxation under this subtitle.

“(4) **CROSS REFERENCE.**—

“For provisions excluding certain de minimis fringes from gross income, see section 132(e).”

(2) **CONFORMING AMENDMENTS.**—

(A) Clause (i) of section 4941(d)(2)(G) is amended by striking out “section 74(b)” and inserting in lieu thereof “section 74(b) (without regard to paragraph (3) thereof)”.

(B) Paragraph (2) of section 4945(g) is amended by striking out “section 74(b)” and inserting in lieu thereof “section 74(b) (without regard to paragraph (3) thereof)”.

(b) **AMOUNTS TRANSFERRED BY EMPLOYER NOT EXCLUDABLE AS GIFTS.**—Section 102 (relating to gifts and inheritances) is amended by adding at the end thereof the following new subsection:

“(c) **EMPLOYEE GIFTS.**—

“(1) **IN GENERAL.**—Subsection (a) shall not exclude from gross income any amount transferred by or for an employer to, or for the benefit of, an employee.

“(2) **CROSS REFERENCES.**—

“For provisions excluding certain employee achievement awards from gross income, see section 74(c).

“For provisions excluding certain de minimis fringes from gross income, see section 132(e).”

(c) **GIFTS.**—Section 274(b) (relating to gifts) is amended—

(1) by adding “or” at the end of subparagraph (A) of paragraph (1),

(2) by striking out “or” at the end of subparagraph (B) of paragraph (1), and inserting in lieu thereof a period,

(3) by striking out subparagraph (C) of paragraph (1), and

(4) by striking out paragraph (3).

(d) **DEDUCTION FOR COST OF EMPLOYEE ACHIEVEMENT AWARDS.**—Section 274 (relating to certain entertainment, etc., expenses) is amended by redesignating subsection (j) as subsection (k) and by inserting after subsection (i) the following new subsection:

“(j) **EMPLOYEE ACHIEVEMENT AWARDS.**—

“(1) **GENERAL RULE.**—No deduction shall be allowed under section 162 or section 212 for the cost of an employee achieve-

ment award except to the extent that such cost does not exceed the deduction limitations of paragraph (2).

“(2) DEDUCTION LIMITATIONS.—The deduction for the cost of an employee achievement award made by an employer to an employee—

“(A) which is not a qualified plan award, when added to the cost to the employer for all other employee achievement awards made to such employee during the taxable year which are not qualified plan awards, shall not exceed \$400. and

“(B) which is a qualified plan award, when added to the cost to the employer for all other employee achievement awards made to such employee during the taxable year (including employee achievement awards which are not qualified plan awards), shall not exceed \$1,600.

“(3) DEFINITIONS.—For purposes of this subsection—

“(A) EMPLOYEE ACHIEVEMENT AWARD.—The term ‘employee achievement award’ means an item of tangible personal property which is—

“(i) transferred by an employer to an employee for length of service achievement or safety achievement,

“(ii) awarded as part of a meaningful presentation, and

“(iii) awarded under conditions and circumstances that do not create a significant likelihood of the payment of disguised compensation.

“(B) QUALIFIED PLAN AWARD.—

“(i) IN GENERAL.—The term ‘qualified plan award’ means an employee achievement award awarded as part of an established written plan or program of the taxpayer which does not discriminate in favor of highly compensated employees (within the meaning of section 414(q)) as to eligibility or benefits.

“(ii) LIMITATION.—An employee achievement award shall not be treated as a qualified plan award for any taxable year if the average cost of all employee achievement awards which are provided by the employer during the year, and which would be qualified plan awards but for this subparagraph, exceeds \$400. For purposes of the preceding sentence, average cost shall be determined by including the entire cost of qualified plan awards, without taking into account employee achievement awards of nominal value.

“(4) SPECIAL RULES.—For purposes of this subsection—

“(A) PARTNERSHIPS.—In the case of an employee achievement award made by a partnership, the deduction limitations contained in paragraph (2) shall apply to the partnership as well as to each member thereof.

“(B) LENGTH OF SERVICE AWARDS.—An item shall not be treated as having been provided for length of service achievement if the item is received during the recipient’s 1st 5 years of employment or if the recipient received a length of service achievement award (other than an award excludable under section 132(e)(1)) during that year or any of the prior 4 years.

“(C) **SAFETY ACHIEVEMENT AWARDS.**—An item provided by an employer to an employee shall not be treated as having been provided for safety achievement if—

“(i) during the taxable year, employee achievement awards (other than awards excludable under section 132(e)(1)) for safety achievement have previously been awarded by the employer to more than 10 percent of the employees of the employer (excluding employees described in clause (ii)), or

“(ii) such item is awarded to a manager, administrator, clerical employee, or other professional employee.”.

(e) **TREATMENT FOR PURPOSES OF EMPLOYMENT TAXES.**—Each of the following provisions are amended by striking out “117 or” and inserting in lieu thereof “74(c), 117, or”:

- (1) Section 3121(a)(20).
- (2) Section 3231(e)(5).
- (3) Section 3306(b)(16).
- (4) Section 3401(a)(20).
- (5) Section 209(s) of the Social Security Act.

SEC. 123. SCHOLARSHIPS.

(a) **IN GENERAL.**—Section 117 (relating to scholarship and fellowship grants) is amended to read as follows:

“SEC. 117. QUALIFIED SCHOLARSHIPS.

“(a) **GENERAL RULE.**—Gross income does not include any amount received as a qualified scholarship by an individual who is a candidate for a degree at an educational organization described in section 170(b)(1)(A)(ii).

“(b) **QUALIFIED SCHOLARSHIP.**—For purposes of this section—

“(1) **IN GENERAL.**—The term ‘qualified scholarship’ means any amount received by an individual as a scholarship or fellowship grant to the extent the individual establishes that, in accordance with the conditions of the grant, such amount was used for qualified tuition and related expenses.

“(2) **QUALIFIED TUITION AND RELATED EXPENSES.**—For purposes of paragraph (1), the term ‘qualified tuition and related expenses’ means—

“(A) tuition and fees required for the enrollment or attendance of a student at an educational organization described in section 170(b)(1)(A)(ii), and

“(B) fees, books, supplies, and equipment required for courses of instruction at such an educational organization.

“(c) **LIMITATION.**—Subsections (a) and (d) shall not apply to that portion of any amount received which represents payment for teaching, research, or other services by the student required as a condition for receiving the qualified scholarship or qualified tuition reduction.

“(d) **QUALIFIED TUITION REDUCTION.**—

“(1) **IN GENERAL.**—Gross income shall not include any qualified tuition reduction.

“(2) **QUALIFIED TUITION REDUCTION.**—For purposes of this subsection, the term ‘qualified tuition reduction’ means the amount of any reduction in tuition provided to an employee of an organization described in section 170(b)(1)(A)(ii) for the edu-

ing or stock bonus plan which includes a qualified cash or deferred arrangement (as defined in section 401(k)(2)) to the extent of amounts which a covered employee may elect to have the employer pay as contributions to a trust under such plan on behalf of the employee.

“(C) EXCEPTION FOR CERTAIN PLANS MAINTAINED BY EDUCATIONAL INSTITUTIONS.—Subparagraph (A) shall not apply to a plan maintained by an educational organization described in section 170(b)(1)(A)(ii) to the extent of amounts which a covered employee may elect to have the employer pay as contributions for post-retirement group life insurance if—

“(i) all contributions for such insurance must be made before retirement, and

“(ii) such life insurance does not have a cash surrender value at any time.

For purposes of section 79, any life insurance described in the preceding sentence shall be treated as group-term life insurance.

“(d) HIGHLY COMPENSATED EMPLOYEE.—For purposes of this section, the term ‘highly compensated employee’ has the meaning given such term by section 414(q).

“(e) QUALIFIED BENEFITS DEFINED.—For purposes of this section—

“(1) IN GENERAL.—The term ‘qualified benefit’ means any benefit which, with the application of subsection (a), is not includible in the gross income of the employee by reason of an express provision of this chapter (other than section 117, 124, 127, or 132).

“(2) CERTAIN BENEFITS INCLUDED.—The term ‘qualified benefits’ includes—

“(A) any group-term life insurance which is includible in gross income only because it exceeds the dollar limitation of section 79, and

“(B) any other benefit permitted under regulations.

“(f) COLLECTIVELY BARGAINED PLAN NOT CONSIDERED DISCRIMINATORY.—For purposes of this section, a plan shall not be treated as discriminatory if the plan is maintained under an agreement which the Secretary finds to be a collective bargaining agreement between employee representatives and one or more employers.

“(g) CROSS REFERENCES.—

“For reporting and recordkeeping requirements, see section 6039D.”

(2) APPLICATION WITH EMPLOYMENT TAXES.—

(A) Section 3121(a)(5) is amended by striking out “or” at the end of subparagraph (E), by inserting “or” at the end of subparagraph (F), and by inserting after subparagraph (F) the following new subparagraph:

“(G) under a cafeteria plan (within the meaning of section 125),”

(B) Section 3306(b)(5) is amended by striking out “or” at the end of subparagraph (E), by inserting “or” at the end of subparagraph (F), and by inserting after subparagraph (F) the following new subparagraph:

“(G) under a cafeteria plan (within the meaning of section 125),”

(C) Section 209(e) of the Social Security Act is amended by inserting before the semicolon at the end thereof the follow-

ing: “, or (9) under a cafeteria plan (within the meaning of section 125 of the Internal Revenue Code of 1986)”.

(e) SPECIAL RULES FOR CONTROLLED GROUPS, ETC.—

(1) IN GENERAL.—Section 414 is amended by adding at the end thereof the following new subsection:

“(t) APPLICATION OF CONTROLLED GROUP RULES TO CERTAIN EMPLOYEE BENEFITS.—

“(1) IN GENERAL.—All employees who are treated as employed by a single employer under subsection (b), (c), or (m) of section 414 shall be treated as employed by a single employer for purposes of an applicable section. The provisions of subsection (o) of section 414 shall apply with respect to the requirements of an applicable section.

“(2) APPLICABLE SECTION.—For purposes of this subsection, the term ‘applicable section’ means section 79, 89, 106, 117(d), 120, 125, 127, 129, 132, 274(j), or 505.”

(2) CONFORMING AMENDMENTS.—

(A) Section 132(g) (relating to special rules relating to employer) is amended to read as follows:

“(g) RECIPROCAL AGREEMENTS.—For purposes of paragraph (1) of subsection (a), any service provided by an employer to an employee of another employer shall be treated as provided by the employer of such employee if—

“(1) such service is provided pursuant to a written agreement between such employers, and

“(2) neither of such employers incurs any substantial additional costs (including foregone revenue) in providing such service or pursuant to such agreement.”

(B) Paragraph (4) of section 505(b) (relating to aggregation rules) is amended to read as follows:

“(4) AGGREGATION RULES.—At the election of the employer, 1 or more plans of such employer may be treated as 1 plan for purposes of this subsection.”

(f) BENEFITS TEST FOR DEPENDENT CARE ASSISTANCE PROGRAMS.—Section 129(d) (relating to dependent care assistance program) is amended by adding at the end thereof the following new paragraph:

“(8) BENEFITS.—

“(A) IN GENERAL.—A plan meets the requirements of this paragraph if the average benefits provided to employee who are not highly compensated employees is at least 5 percent of the average benefits provided to highly compensated employees.

“(B) SALARY REDUCTION AGREEMENTS.—For purposes of subparagraph (A), in the case of any benefits provided through a salary reduction agreement, there shall be disregarded any employees whose compensation (within the meaning of section 415(q)(7)) is less than \$25,000.”

(g) DEFINITION OF EXCLUDABLE EMPLOYEE.—

(1) Section 120(c)(2) is amended by striking out the last sentence thereof and inserting in lieu thereof “For purposes of this paragraph, there may be excluded from consideration employees who may be excluded from consideration under section 89(h).”

(2) Section 117(d) is amended by adding at the end thereof the following new paragraph:

“(4) EXCLUSION OF CERTAIN EMPLOYEES.—For purposes of this subsection, there may be excluded from consideration

(1) **IN GENERAL.**—The Secretary of the Treasury or his delegate shall conduct a study of the incidence of the evasion of the gasoline tax.

(2) **REPORT.**—The report of the study under paragraph (1) shall be submitted, not later than December 31, 1986, to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

(h) **EFFECTIVE DATE.**—The amendments made by this section shall apply to gasoline removed (as defined in section 4082 of the Internal Revenue Code of 1986, as amended by this section) after December 31, 1987.

SEC. 1704. EXEMPTION FROM SOCIAL SECURITY COVERAGE FOR CERTAIN CLERGY.

(a) CONDITIONS FOR RECEIVING EXEMPTION.—

(1) **IN GENERAL.**—Section 1402(e)(1) (relating to exemption from tax on self-employment income of certain ministers, members of religious orders, and Christian Science practitioners) is amended by inserting “and, in the case of an individual described in subparagraph (A), that he has informed the ordaining, commissioning, or licensing body of the church or order that he is opposed to such insurance” after “Act”).

(2) **VERIFICATION OF APPLICATION.**—Section 1402(e), as amended by paragraph (1) of this subsection, is further amended—

(A) by striking out “Any individual” in paragraph (1) and inserting in lieu thereof “Subject to paragraph (2), any individual”,

(B) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively, and

(C) by inserting after paragraph (1) the following new paragraph:

“(2) **VERIFICATION OF APPLICATION.**—The Secretary may approve an application for an exemption filed pursuant to paragraph (1) only if the Secretary has verified that the individual applying for the exemption is aware of the grounds on which the individual may receive an exemption pursuant to this subsection and that the individual seeks exemption on such grounds. The Secretary (or the Secretary of Health and Human Services under an agreement with the Secretary) shall make such verification by such means as prescribed in regulations.”

(3) **EFFECTIVE DATE.**—The amendments made by paragraphs (1) and (2) shall apply to applications filed after December 31, 1986.

(b) REVOCATION OF EXEMPTION.—

(1) **IN GENERAL.**—Notwithstanding section 1402(e)(3) of the Internal Revenue Code of 1986, as redesignated by subsection (a)(2)(B) of this section, any exemption which has been received under section 1402(e)(1) of such Code by a duly ordained, commissioned, or licensed minister of a church, a member of a religious order, or a Christian Science practitioner, and which is effective for the taxable year in which this Act is enacted, may be revoked by filing an application therefor (in such form and manner, and with such official, as may be prescribed in regulations made under chapter 2 of subtitle A of such Code), if such application is filed—

(A) before the applicant becomes entitled to benefits under section 202(a) or 223 of the Social Security Act (without regard to section 202(j)(1) or 223(b) of such Act), and

(B) no later than the due date of the Federal income tax return (including any extension thereof) for the applicant's first taxable year beginning after the date of the enactment of this Act.

Any such revocation shall be effective (for purposes of chapter 2 of subtitle A of the Internal Revenue Code of 1986 and title II of the Social Security Act), as specified in the application, either with respect to the applicant's first taxable year ending on or after the date of the enactment of this Act or with respect to the applicant's first taxable year beginning after such date, and for all succeeding taxable years; and the applicant for any such revocation may not thereafter again file application for an exemption under such section 1402(e)(1). If the application is filed on or after the due date of the Federal income tax return for the applicant's first taxable year ending on or after the date of the enactment of this Act and is effective with respect to that taxable year, it shall include or be accompanied by payment in full of an amount equal to the total of the taxes that would have been imposed by section 1401 of the Internal Revenue Code of 1986 with respect to all of the applicant's income derived in that taxable year which would have constituted net earnings from self-employment for purposes of chapter 2 of subtitle A of such Code (notwithstanding paragraph (4) or (5) of section 1402(c) of such Code) but for the exemption under section 1402(e)(1) of such Code.

(2) **EFFECTIVE DATE.**—Paragraph (1) of this subsection shall apply with respect to service performed (to the extent specified in such paragraph) in taxable years ending on or after the date of the enactment of this Act and with respect to monthly insurance benefits payable under title II of the Social Security Act on the basis of the wages and self-employment income of any individual for months in or after the calendar year in which such individual's application for revocation (as described in such paragraph) is effective (and lump-sum death payments payable under such title on the basis of such wages and self-employment income in the case of deaths occurring in or after such calendar year).

SEC. 1705. APPLICABILITY OF UNEMPLOYMENT COMPENSATION TAX TO CERTAIN SERVICES PERFORMED FOR CERTAIN INDIAN TRIBAL GOVERNMENTS.

(a) **IN GENERAL.**—For purposes of the Federal Unemployment Tax Act, service performed in the employ of a qualified Indian tribal government shall not be treated as employment (within the meaning of section 3306 of such Act) if it is service—

(1) which is performed—

(A) before, on, or after the date of the enactment of this Act, but before January 1, 1988, and

(B) during a period in which the Indian tribal government is not covered by a State unemployment compensation program, and

(2) with respect to which the tax imposed under the Federal Unemployment Tax Act has not been paid.

after the date designated under section 112 as the date of termination of combatant activities in a combat zone.”

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 1982.

SEC. 1709. AMENDMENT TO THE REINDEER INDUSTRY ACT OF 1937.

(a) **TAX EXEMPTION FOR REINDEER-RELATED INCOME.**—Before the period at the end of the first sentence of section 8 of the Act of September 1, 1937 (50 Stat. 900, chapter 897), insert the following: “: *Provided*, That during the period of the trust, income derived directly from the sale of reindeer and reindeer products as provided in this Act shall be exempt from Federal income taxation”.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall take effect as if originally included in the provision of the Act of September 1, 1937, to which such amendment relates.

SEC. 1710. QUALITY CONTROL STUDIES.

Section 12301 of the Consolidated Omnibus Reconciliation Act of 1985 is amended—

(1) by striking out “of the enactment of this Act” in subsection (a)(3) and inserting in lieu thereof “the Secretary and the National Academy of Sciences enter into the contract required under paragraph (2)”;

(2) by striking out “18 months after the date of the enactment of this Act” in subsection (c)(1) and inserting in lieu thereof “6 months after the date on which the results of both studies required under subsection (a)(3) have been reported”.

SEC. 1711. ADOPTION ASSISTANCE AGREEMENTS UNDER ADOPTION ASSISTANCE PROGRAM: PAYMENT OF NONRECURRING EXPENSES RELATED TO ADOPTIONS OF CHILDREN WITH SPECIAL NEEDS.

(a) **IN GENERAL.**—Section 473(a) of the Social Security Act is amended—

(1) by redesignating paragraphs (2), (3), and (4) as paragraphs (3), (4), and (5), respectively, and

(2) by striking out all of paragraph (1) through “adopt a child who—” and inserting in lieu thereof the following:

“(1)(A) Each State having a plan approved under this part shall enter into adoption assistance agreements (as defined in section 475(3)) with the adoptive parents of children with special needs.

“(B) Under any adoption assistance agreement entered into by a State with parents who adopt a child with special needs, the State—

“(i) shall make payments of nonrecurring adoption expenses incurred by or on behalf of such parents in connection with the adoption of such child, directly through the State agency or through another public or nonprofit private agency, in amounts determined under paragraph (3), and

“(ii) in any case where the child meets the requirements of paragraph (2), may make adoption assistance payments to such parents, directly through the State agency or through another public or nonprofit private agency, in amounts so determined.

“(2) For purposes of paragraph (1)(B)(ii), a child meets the requirements of this paragraph if such child—

(b) **DEFINITION AND PAYMENT OF NONRECURRING ADOPTION EXPENSES.**—Section 473(a) of the Social Security Act, as amended by

subsection (a) of this section, is further amended by adding at the end thereof the following new paragraph:

“(6)(A) For purposes of paragraph (1)(B)(i), the term ‘nonrecurring adoption expenses’ means reasonable and necessary adoption fees, court costs, attorney fees, and other expenses which are directly related to the legal adoption of a child with special needs and which are not incurred in violation of State or Federal law.

“(B) A State’s payment of nonrecurring adoption expenses under an adoption assistance agreement shall be treated as an expenditure made for the proper and efficient administration of the State plan for purposes of section 474(a)(3)(B).”

(c) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) The first sentence of section 470 of the Social Security Act is amended by striking out “foster care” and all that follows down through “title XVI)” and inserting in lieu thereof the following: “foster care and transitional independent living programs for children who otherwise would be eligible for assistance under the State’s plan approved under part A and adoption assistance for children with special needs”.

(2) Paragraphs (1) and (11) of section 471(a) of such Act are each amended by striking out “adoption assistance payments” and inserting in lieu thereof “adoption assistance”

(3) Section 473(a)(3) of such Act, as redesignated by subsection (a)(1) of this section, is amended—

(A) by striking out “adoption assistance payments” in the first sentence and inserting in lieu thereof “payments to be made in any case under clauses (i) and (ii) of paragraph (1)(B)”, and

(B) by inserting after “the adoption assistance payment” the first place it appears in the second sentence the following: “made under clause (ii) of paragraph (1)(B)”.

(4) Section 473(a)(5) of such Act, as so redesignated, is amended by striking out “, pursuant to an interlocutory decree, shall be eligible for adoption assistance payments under this subsection,” and inserting in lieu thereof “in accordance with applicable State and local law shall be eligible for such payments,”.

(5) Section 473(b)(1)(A) of such Act is amended by striking out “subsection (a)(1)” and inserting in lieu thereof “subsection (a)(2)”.

(6) Section 475(3) of such Act is amended by striking out clause (A) and inserting in lieu thereof the following: “(A) specifies the nature and amount of any payments, services, and assistance to be provided under such agreement, and”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply only with respect to expenditures made after December 31, 1986.

TITLE XVIII—TECHNICAL CORRECTIONS

SEC. 1800. COORDINATION WITH OTHER TITLES.

For purposes of applying the amendments made by any title of this Act other than this title, the provisions of this title shall be treated as having been enacted immediately before the provisions of such other titles.

CHAPTER 8—EFFECTIVE DATE**SEC. 1881. EFFECTIVE DATE.**

Except as otherwise provided in this subtitle, any amendment made by this subtitle shall take effect as if included in the provision of the Tax Reform Act of 1984 to which such amendment relates.

Subtitle B—Related to Other Programs Affected by the Deficit Reduction Act of 1984

CHAPTER 1—AMENDMENTS RELATED TO SOCIAL SECURITY ACT PROGRAMS

SEC. 1882. AMENDMENTS RELATED TO COVERAGE OF CHURCH EMPLOYEES (SECTION 2603 OF THE DEFICIT REDUCTION ACT).

(a) **CLARIFICATION OF EXCEPTION FOR MEMBERS OF CERTAIN RELIGIOUS FAITHS.**—Subsection (g) of section 1402 of the Internal Revenue Code of 1954 (relating to members of certain religious faiths) is amended by adding at the end thereof the following new paragraph:

“(5) **SUBSECTION NOT TO APPLY TO CERTAIN CHURCH EMPLOYEES.**—This subsection shall not apply with respect to services which are described in subparagraph (B) of section 3121(b)(8) (and are not described in subparagraph (A) of such section).”

(b) **TREATMENT OF INCOME OF CERTAIN CHURCH, ETC., EMPLOYEES.**—

(1) **AMENDMENTS OF INTERNAL REVENUE CODE OF 1954.**—

(A) **IN GENERAL.**—Section 1402 of such Code (relating to definitions for purposes of the tax on self-employment income) is amended by adding at the end thereof the following new subsection:

“(j) **SPECIAL RULES FOR CERTAIN CHURCH EMPLOYEE INCOME.**—

“(1) **COMPUTATION OF NET EARNINGS.**—In applying subsection

(a)—

“(A) church employee income shall not be reduced by any deduction;

“(B) church employee income and deductions attributable to such income shall not be taken into account in determining the amount of other net earnings from self-employment.

“(2) **COMPUTATION OF SELF-EMPLOYMENT INCOME.**—

“(A) **SEPARATE APPLICATION OF SUBSECTION (b)(2).**—Paragraph (2) of subsection (b) shall be applied separately—

“(i) to church employee income, and

“(ii) to other net earnings from self-employment.

“(B) **\$100 FLOOR.**—In applying paragraph (2) of subsection (b) to church employee income, ‘\$100’ shall be substituted for ‘\$400’.

“(3) **COORDINATION WITH SUBSECTION (a)(12).**—Paragraph (1) shall not apply to any amount allowable as a deduction under subsection (a)(12), and paragraph (1) shall be applied before determining the amount so allowable.

“(4) **CHURCH EMPLOYEE INCOME DEFINED.**—For purposes of this section, the term ‘church employee income’ means gross income

for services which are described in section 3121(b)(8)(B) (and are not described in section 3121(b)(8)(A)).”

(B) TECHNICAL AND CONFORMING AMENDMENTS.—

(i) NET EARNINGS.—Paragraph (14) of section 1402(a) of such Code (defining net earnings from self-employment) is amended to read as follows:

“(14) in the case of church employee income, the special rules of subsection (j)(1) shall apply.”

(ii) SELF-EMPLOYMENT INCOME.—Subsection (b) of section 1402 of such Code is amended by adding at the end thereof the following new sentence: “In the case of church employee income, the special rules of subsection (j)(2) shall apply for purposes of paragraph (2).”

(iii) CONFORMING AMENDMENT.—The second sentence of section 1402(b) of such Code is amended by striking out “clause (1)” and inserting in lieu thereof “paragraph (1)”.

(2) AMENDMENTS OF SOCIAL SECURITY ACT.—

(A) IN GENERAL.—Section 211 of the Social Security Act is amended by adding at the end thereof the following new subsection:

“(i)(1) In applying subsection (a)—

“(A) church employee income shall not be reduced by any deduction;

“(B) church employee income and deductions attributable to such income shall not be taken into account in determining the amount of other net earnings from self-employment.

“(2)(A) Subsection (b)(2) shall be applied separately—

“(i) to church employee income, and

“(ii) to other net earnings from self-employment.

“(B) In applying subsection (b)(2) to church employee income, ‘\$100’ shall be substituted for ‘\$400’.

“(3) Paragraph (1) shall not apply to any amount allowable as a deduction under subsection (a)(11), and paragraph (1) shall be applied before determining the amount so allowable.

“(4) For purposes of this section, the term ‘church employee income’ means gross income for services which are described in section 210(a)(8)(B) (and are not described in section 210(a)(8)(A)).”

(B) TECHNICAL AND CONFORMING AMENDMENTS.—

(i) NET EARNINGS.—Section 211(a)(13) of such Act is amended to read as follows:

“(13) In the case of church employee income, the special rules of subsection (i)(1) shall apply.”

(ii) SELF-EMPLOYMENT INCOME.—Section 211(b) of such Act is amended by adding at the end thereof the following new sentence: “In the case of church employee income, the special rules of subsection (i)(2) shall apply for purposes of paragraph (2).”

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to remuneration paid or derived in taxable years beginning after December 31, 1985.

(c) REVOCATION OF ELECTION UNDER SECTION 3121(w).—Paragraph (2) of section 3121(w) of the Internal Revenue Code of 1954 (relating to timing and duration of election) is amended by striking out the last 2 sentences and inserting in lieu thereof the following: “The election may be revoked by the church or organization under regulations prescribed by the Secretary. The election shall be revoked by

the Secretary if such church or organization fails to furnish the information required under section 6051 to the Secretary for a period of 2 years or more with respect to remuneration paid for such services by such church or organization, and, upon request by the Secretary, fails to furnish all such previously unfurnished information for the period covered by the election. Any revocation under the preceding sentence shall apply retroactively to the beginning of the 2-year period for which the information was not furnished."

SEC. 1883. TECHNICAL CORRECTIONS IN OTHER PROVISIONS RELATED TO SOCIAL SECURITY ACT PROGRAMS.

(a) AMENDMENTS RELATING TO OASDI PROGRAM.—

(1) Section 202(c)(5)(B) of the Social Security Act is amended by striking out "or (I)" and inserting in lieu thereof "or (J)".

(2) Section 202(q)(5)(A)(i) of such Act is amended by striking out "prescribed by him" and inserting in lieu thereof "prescribed by the Secretary".

(3) Section 202(q)(5)(C) of such Act is amended by striking out "she shall be deemed" and inserting in lieu thereof "he or she shall be deemed".

(4) Section 210(a)(5)(G) of such Act is amended by striking out "Any other service" and inserting in lieu thereof "any other service".

(5) Effective on the date of the enactment of the Deficit Reduction Act of 1984—

(A) section 2601(d)(1)(B)(ii) of that Act is amended by striking out "210(a)(5)(g)(iii)" and inserting in lieu thereof "210(a)(5)(G)(iii)"; and

(B) section 2663(c)(1) of that Act is amended by striking out subparagraph (B).

(6) Section 211(c)(2) of the Social Security Act is amended by indenting subparagraph (G) two additional ems (for a total indentation of four ems) so as to align its left margin with the margins of the other subparagraphs in such section.

(7) Section 215(i)(5)(B) of such Act is amended—

(A) by striking out "subdivision (I)" in clause (ii) and inserting in lieu thereof "clause (i)(I)"; and

(B) by striking out "subdivisions (I) and (II)" in the matter between clauses (iii) and (iv) and inserting in lieu thereof "clause (i)".

(8) The heading of section 218(m) of such Act is amended to read as follows:

"Wisconsin Retirement Fund".

(9) Section 221(e) of such Act is amended by striking out "under this section" in the first sentence.

(10) Section 223(g)(1) of such Act is amended by striking out the second comma after the term "benefits" where such term first appears in the matter following subparagraph (C).

(11)(A) Section 1402(c)(2) of the Internal Revenue Code of 1954 is amended by indenting subparagraph (G) two additional ems (for a total indentation of four ems) so as to align its left margin with the margins of the other subparagraphs in such section.

(B) Section 3121(a)(8) of such Code is amended by moving subparagraph (B) two ems to the left, so that its left margin is in

flush alignment with the margin of subparagraph (A) of such section.

(b) AMENDMENTS RELATING TO AFDC AND CHILD SUPPORT PROGRAMS.—

(1)(A) Section 402(a)(31)(A) of the Social Security Act is amended by striking out “(or such lesser amount as the Secretary may prescribe in the case of an individual not engaged in fulltime employment or not employed throughout the month)”.

(B) The amendment made by this paragraph shall be effective beginning October 1, 1984.

(2)(A) Section 402(a)(38)(B) of such Act is amended by striking out “section 406(a),” and inserting in lieu thereof “section 406(a) or in section 407(a) (if such section is applicable to the State).”.

(B) Section 402(a)(38) of such Act (as amended by subparagraph (A) of this paragraph) is further amended by relocating so much of subparagraph (B) as follows “section 407(a) (if such section is applicable to the State),” and placing it after and below subparagraph (B), beginning flush, and indenting it two ems so that its left margin is aligned with the left margin of that portion of section 402(a)(38) that precedes subparagraph (A) thereof.

(C) The amendments made by this paragraph shall be effective beginning October 1, 1984.

(3)(A) Section 402(a)(39) of such Act is amended by striking out “under the age selected by the State pursuant to section 406(a)(2)” and inserting in lieu thereof “under the age of 18”.

(B) The amendment made by subparagraph (A) shall be effective beginning October 1, 1984.

(4)(A) Section 402(a) of such Act is amended by striking out “and” after the semicolon at the end of paragraph (37), and by making any additional changes which may be necessary to assure that paragraphs (34) through (37) each end with a semicolon, paragraph (38) ends with “; and”, and paragraph (39) ends with a period.

(B) Effective on the date of the enactment of the Deficit Reduction Act of 1984, section 2639(a) of that Act is amended by striking out the period immediately following “utility providing home energy” (in the quoted matter) and inserting in lieu thereof a semicolon.

(5) The placement of the last sentence of section 402(a) of the Social Security Act is modified to the extent necessary to assure that it begins flush to the full left margin without any indentation, immediately after and below the last of the numbered paragraphs.

(6) Section 457(c) of such Act is amended by striking out “subsection (b)(3) (A) and (B)” in the matter following paragraph (2) and inserting in lieu thereof “subsection (b)(4) (A) and (B)”.

(7) Section 458(d) of such Act is amended by striking out “on behalf of individuals residing in another State” and inserting in lieu thereof “at the request of another State”.

(8) Section 464(b)(2)(A) of such Act is amended by striking out “threshold” and inserting in lieu thereof “threshold”.

(9) Section 474(a) of such Act is amended by moving paragraph (4) two ems to the left, so that its left margin is in flush alignment with the margins of the preceding paragraphs.

(10)(A) Part E of title IV of such Act is amended by adding at the end thereof the following new section:

**“EXCLUSION FROM AFDC UNIT OF CHILD FOR WHOM FOSTER CARE
MAINTENANCE PAYMENTS ARE MADE**

“SEC. 478. Notwithstanding any other provision of this title, a child with respect to whom foster care maintenance payments are made under this part shall not, for the period for which such payments are made, be regarded as a member of a family for purposes of determining the amount of the benefits of the family under part A, and the income and resources of such child shall not be counted as the income and resources of a family under such part.”

(B) The amendment made by subparagraph (A) shall become effective October 1, 1984.

(11)(A) The failure by a State to comply with the provisions of any amendment made by paragraph (1), (2), (3), or (10) or the imposition by a State of any requirement inconsistent with such provisions, in the administration of its plan approved under section 402(a) of the Social Security Act during the period beginning October 1, 1984, and ending on the day preceding the date of the enactment of this Act, shall not be considered to be failure to comply substantially with a provision required to be included in the State's plan, or to constitute (solely by reason of such inconsistency) the imposition of a prohibited requirement in the administration of the plan, for purposes of section 404(a) of such Act.

(B) No State shall be considered to have made any overpayment or underpayment of aid, under its plan approved under section 402(a) of the Social Security Act, by reason of its compliance or noncompliance with the provisions of any amendment made by paragraph (1), (2), (3), or (10) (or solely because of the extent to which its requirements are consistent or inconsistent with such provisions) in the administration of the plan during the period specified in subparagraph (A).

(c) AMENDMENTS TO GENERAL PROVISIONS.—

(1) Section 1101(a) of such Act is amended by shifting paragraphs (3), (4), and (5) to the right to the extent necessary to assure that their left margins are aligned with the left margins of the other numbered paragraphs.

(2) Section 1136(b)(7) of such Act is amended by striking out “nongovernmental” and inserting in lieu thereof “nongovernmental”.

(d) AMENDMENTS RELATING TO SSI PROGRAM.—

(1) The heading of section 1631(g) of such Act is amended to read as follows:

“Reimbursement to States for Interim Assistance Payments”.

(2) Section 1612(a)(1)(C) of such Act is amended by striking out “section 43” and inserting in lieu thereof “section 32”.

(3) Section 1612(b) of such Act is amended—

(A) by striking out the semicolon at the end of paragraph (2)(A) and inserting in lieu thereof “, and”;

(B) by striking out the period at the end of paragraph (2)(B) and inserting in lieu thereof a semicolon; and

(C) by making any changes which may be necessary to assure that paragraph (11) ends with a semicolon, para-

graph (12) ends with “; and”, and paragraph (13) ends with a period.

(e) **AMENDMENTS RELATING TO SOCIAL SERVICES PROGRAM.**—

(1)(A) Section 2003(d) of such Act is repealed.

(B) Section 2003(b) of such Act is amended by striking out “(subject to subsection (d))”.

(2) Section 2007 of such Act is repealed.

(f) **EFFECTIVE DATE.**—Except as otherwise provided in this section, the amendments made by this section shall take effect on the date of the enactment of this Act.

CHAPTER 2—AMENDMENTS RELATED TO UNEMPLOYMENT COMPENSATION PROGRAM

SEC. 1884. TECHNICAL CORRECTIONS IN FEDERAL UNEMPLOYMENT TAX ACT.

The Federal Unemployment Tax Act is amended as follows:

(1) Subparagraph (B) of section 3302(c)(2) (relating to a limit on the credit against the unemployment tax) is amended—

(A) by striking out “determination” the second place it appears in the material preceding clause (i) and inserting in lieu thereof “denominator”, and

(B) in clause (i)—

(i) by striking out “percent” immediately preceding the comma at the end thereof, and

(ii) by inserting “percent” after “2.7”.

(2) Subparagraph (A) of section 3302(f)(8) (relating to a partial limitation on the reduction of the credit against the unemployment tax) is amended by striking out “1987” and inserting in lieu thereof “1986”.

(3) Clause (i) of section 3306(o)(1)(A) (relating to crew leaders who are registered or provide specialized agricultural labor) is amended by striking out “Farm Labor Contractor Registration Act of 1963” and inserting in lieu thereof “Migrant and Seasonal Agricultural Worker Protection Act”.

CHAPTER 3—AMENDMENTS RELATED TO TRADE AND TARIFF PROGRAMS

SEC. 1885. AMENDMENTS TO THE TARIFF SCHEDULES.

(a) **IN GENERAL.**—The Tariff Schedules of the United States are amended as follows:

(1) **TELECOMMUNICATIONS PRODUCT CLASSIFICATION CORRECTIONS.**—

(A) Schedule 6 is amended as follows:

(i) Headnote 1 to subpart C of part 4 is amended by striking out “688.43” and inserting in lieu thereof “688.42”.

(ii) Headnote 3 of part 5 of schedule 6 is amended by striking out “items 685.11 through 685.19, inclusive,” and inserting in lieu thereof “items 684.92, 684.98, 685.00, and 685.08”.

(iii) Item 685.34 is amended by inserting “35% ad val.” in Column No. 2.

(iv) Item 685.55 is amended by striking out “685.11 to 685.50” and inserting in lieu thereof “684.92 to 685.49”.

(B) the amount of fees such person would have been required to pay to the Secretary by reason of such section with respect to such services if the amendments made by subsections (a)(1) and (b) applied with respect to such services.

(3) If the customs broker permit fee paid by any person for calendar year 1986 under section 13031(a)(7) of the Consolidated Omnibus Budget Reconciliation Act of 1985 exceeds \$62.50, the Secretary shall either—

(A) refund (out of funds in the Treasury of the United States not otherwise appropriated) to such person the amount of the excess, or

(B) if requested by such person, credit the amount of the excess to the fee due under such section 13031(a)(7) with respect to such permit for calendar year 1987.

SEC. 1894. FOREIGN TRADE ZONES.

Section 3 of the Act of June 18, 1934 (48 Stat. 999, chapter 590; 19 U.S.C. 81c) is amended by adding at the end thereof the following new subsection:

“(c) Notwithstanding the provisions of the fifth proviso of subsection (a), any article (within the meaning of section 5002(a)(14) of the Internal Revenue Code of 1986) may be manufactured or produced from domestic denatured distilled spirits, and articles thereof, in a zone.”

Subtitle C—Miscellaneous

CHAPTER 1—AMENDMENTS RELATED TO THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

SEC. 1895. COBRA TECHNICAL CORRECTIONS RELATING TO SOCIAL SECURITY ACT PROGRAMS.

(a) AMENDMENT RELATING TO THE OASDI PROGRAM.—Section 12108(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking out “1985” and inserting in lieu thereof “1986”.

(b) AMENDMENTS RELATING TO THE MEDICARE PROGRAM.—

(1) INDIRECT MEDICAL EDUCATION.—(A) Paragraph (2)(C)(i) of subsection (d) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by striking out “(taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985)”.

(B) Paragraph (3)(A) of such subsection is amended by adding at the end the following: “If the formula under paragraph (5)(B) for determining payments for the indirect costs of medical education is changed for any fiscal year, the Secretary shall readjust the standardized amounts previously determined for each hospital to take into account the changes in that formula.”.

(C) Clause (ii) of paragraph (3)(C) of such subsection is amended to read as follows:

“(ii) **REDUCING FOR SAVINGS FROM AMENDMENT TO INDIRECT TEACHING ADJUSTMENT FOR DISCHARGES AFTER SEPTEMBER 30, 1986.**—The Secretary shall further reduce each of the average standardized amounts by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which is the difference between—

“(I) the sum of the additional payment amounts under paragraph (5)(B) (relating to indirect costs of medical education) if the indirect teaching adjustment factor were equal to 1.159r (as ‘r’ is defined in paragraph (5)(B)(ii)), and

“(II) that sum using the factor specified in paragraph (5)(B)(ii)(I).”.

(D)(i) Except as provided in clause (ii), the amendments made by this paragraph apply to discharges occurring on or after October 1, 1986.

(ii) The amendments made by this paragraph shall not be first applied to discharges occurring as of a date unless, for discharges occurring on that date, the amendments made by section 9105(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (incorporating the amendments made by paragraph (2) of this subsection) are also being applied.

(2) **DISPROPORTIONATE SHARE.**—(A) Paragraph (2)(C) of subsection (d) of section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 9105(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (in this section referred to as “COBRA”) is amended—

(i) by adding “and” at the end of clause (ii),

(ii) by striking out “, and” at the end of clause (iii) and inserting in lieu thereof a period, and

(iii) by striking out clause (iv).

(B) Paragraph (3)(C) of such subsection is amended by adding at the end the following:

“(iii) **REDUCING FOR DISPROPORTIONATE SHARE PAYMENTS.**—The Secretary shall further reduce each of the average standardized amounts by reducing the standardized amount for each hospital (as previously determined without regard to this clause) by a proportion equal to the proportion (established by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which are additional payments described in paragraph (5)(F) (relating to disproportionate share payments) for subsection (d) hospitals.”.

(C) Paragraph (5)(F)(vi)(I) of such subsection is amended—

(i) by striking out “supplementary” and inserting in lieu thereof “supplemental”, and

(ii) by striking out “fiscal year” and inserting in lieu thereof “period”.

(D) The amendments made by subparagraph (C) apply to discharges occurring on or after May 1, 1986, and the amendments made by subparagraphs (A) and (B) apply to discharges occurring on or after October 1, 1986.

(3) **ALIGNMENT CORRECTION.**—Subparagraph (B) of section 1886(g)(2) of the Social Security Act (as added by section 9107(a)(1)(C) of the Consolidated Omnibus Budget Reconciliation Act of 1985) is amended by moving its alignment (and the alignment of each of its clauses) two additional ems to the left.

(4) **EMERGENCY CARE REQUIREMENT.**—Section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)), as inserted by section 9121(b) of COBRA, is amended by striking out “and has, under the agreement, obligated itself to comply with the requirements of this section”.

(5) **REDESIGNATING OVERLAPPING PROVISIONS.**—Paragraph (1) of section 1866(a) of the Social Security Act (42 U.S.C. 1395cc(a)) is amended—

(A) by striking out “and” inserted at the end of subparagraph (I) by section 9122(a)(2) of COBRA,

(B) by striking out the period at the end of subparagraph (J) and inserting in lieu thereof “, and”, and

(C) by redesignating the subparagraph (I) inserted by section 9403(b) of COBRA as subparagraph (K) and transferring and inserting such subparagraph after subparagraph (J).

(6) **CHAMPUS.**—Section 9122(b) of COBRA is amended by striking out “to agreements entered into or renewed on or after the date of the enactment of this Act, but shall apply only”.

(7) **SKILLED NURSING FACILITY PAYMENTS.**—(A) Section 1888(d)(1) of the Social Security Act (42 U.S.C. 1395yy(d)(1)), as added by section 9126(a) of COBRA, is amended by striking out “fiscal year” each place it appears and inserting in lieu thereof “cost reporting period”.

(B) Section 1888(d)(4) of the Social Security Act is amended—

(i) in the first sentence, by striking out “each fiscal year” and inserting in lieu thereof “cost reporting periods beginning in a fiscal year”, and

(ii) in the second sentence, by striking out “fiscal year” and all that follows up to the period and inserting in lieu thereof “cost reporting period no later than 30 days before the beginning of that period”.

(C) Section 9126(d)(1) of COBRA is amended by striking out “fiscal years” and inserting in lieu thereof “cost reporting periods”.

(D) The amendments made by subparagraphs (A) and (B) apply to cost reporting periods beginning on or after October 1, 1986.

(8) **PROPAC.**—Section 9127(b) of COBRA is amended by inserting “, except that the Director may provide initially for such terms as will insure that (on a continuing basis) the terms of no more than eight members will expire in any one year” after “years”.

(9) **DIRECT MEDICAL EDUCATION.**—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)), added by 9202(a) of COBRA, is amended—

(A) in paragraph (2)(C), by striking out “paragraph (B)” and inserting in lieu thereof “subparagraph (B)”,

(B) in the matter preceding subclause (I) of paragraph (4)(E)(ii), by inserting “but before July 1, 1987,” after “1986,”,

(C) by redesignating subparagraph (E) of paragraph (4) as subparagraph (D), and

(D) in paragraph (5)(B), by striking out “As used in this paragraph, the” and inserting in lieu thereof “The”.

(10) **CITATION CORRECTION.**—Section 9202(j) of COBRA is amended by inserting “or section 402 of the Social Security

Amendments of 1967" after "section 1886(c) of the Social Security Act".

(11) **HMO/CMP RATES.**—(A) The matter in section 1876(a)(1)(A) of the Social Security Act (42 U.S.C. 1395mm(a)(1)(A)) preceding clause (i), as amended by section 9211(d) of COBRA, is amended by striking out "publish" and inserting in lieu thereof "announce (in a manner intended to provide notice to interested parties)".

(B) The amendment made by subparagraph (A) shall apply to determinations of per capita payment rates for 1987 and subsequent years.

(12) **INDENTATION.**—Section 1837(i)(1) of the Social Security Act (42 U.S.C. 1395p(i)(1)), as amended by section 9219(a)(2)(A) of COBRA, is amended by moving the alignment of subparagraph (A) two additional ems to the left so as to align its left margin with the left margins of subparagraphs (B) and (C) of such section.

(13) **ACCESS DEMONSTRATION PROJECT.**—Section 9221(a) of COBRA is amended by striking out "September 30, 1986" and inserting in lieu thereof "July 31, 1987".

(14) **PHYSICIAN PAYMENT.**—(A) Section 1842(b)(4)(C) of the Social Security Act (42 U.S.C. 1395u(b)(4)(C)), as amended by section 9301(b)(1)(C) of COBRA, is amended—

(i) by striking out clause (ii), and

(ii) by striking out "(i)" in clause (i).

(B) Section 9301(c)(5) of COBRA is amended by striking out "1842(b)(7)" and inserting in lieu thereof "1842(h)(7)".

(15) **REDUNDANT WORDS.**—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)), as amended by section 9301(c) of COBRA, is amended—

(A) in paragraph (5), as redesignated by section 9301(c)(3)(D) of COBRA, by striking out "such" each place it appears, and

(B) in paragraph (6); as so redesignated, by striking out "the the" and inserting in lieu thereof "the".

(16) **ASSISTANTS AT SURGERY.**—(A) Section 1842(k) of the Social Security Act (42 U.S.C. 1395u(k)), added by section 9307(c) of COBRA, is amended by inserting "presents or causes to be presented a claim or" after "willfully" each place it appears.

(B) The amendment made by subparagraph (A) shall apply to claims presented after the date of the enactment of this Act.

(C) For purposes of section 1862(a)(15) of the Social Security Act (42 U.S.C. 1395y(a)(15)), added by section 9307(a)(3) of COBRA, and for surgical procedures performed during the period beginning on April 1, 1986, and ending on December 15, 1986, a carrier is deemed to have approved the use of an assistant in a surgical procedure, before the surgery is performed, based on the existence of a complicating medical condition if the carrier determines after the surgery is performed that the use of the assistant in the procedure was appropriate based on the existence of a complicating medical condition before or during the surgery.

(17) **CITATION.**—Section 1164(b)(4)(B) of the Social Security Act (42 U.S.C. 1320c-13(b)(4)(B)), as added by section 9401(b) of COBRA, is amended by striking out "paragraphs" and inserting in lieu thereof "subparagraphs".

(18) **MEDICARE TAX ON STATE AND LOCAL EMPLOYEES.**—(A) Section 3121(u)(2)(B)(ii) of the Internal Revenue Code of 1954, as added by section 13205(a)(1) of COBRA, is amended—

- (i) by striking out “or” at the end of subclause (III),
- (ii) by striking out the period at the end of subclause (IV) and inserting in lieu thereof “, or”, and
- (iii) by adding at the end the following:

“(V) by an election official or election worker if the remuneration paid in a calendar year for such service is less than \$100.”

(B) Section 210(p)(2) of the Social Security Act (42 U.S.C. 410(p)(2)), as added by section 13205(b)(1) of COBRA, is amended—

- (i) by striking out “or” at the end of subparagraph (C),
- (ii) by striking out the period at the end of subparagraph (D) and inserting in lieu thereof “, or”, and
- (iii) by adding at the end the following:

“(E) by an election official or election worker if the remuneration paid in a calendar year for such service is less than \$100.”

(C) The amendments made by this paragraph shall apply to services performed after March 31, 1986.

(19) **PUNCTUATION.**—Section 210(p)(4)(B) of the Social Security Act (42 U.S.C. 410(p)(4)(B)), as amended by section 13205(b)(1) of COBRA, is amended by striking out any quotation marks that appear before “(A)”.

(c) **AMENDMENTS RELATING TO THE MEDICAID PROGRAM.**—

(1) **EXTRA WORD.**—Section 1902(a)(13)(D) of the Social Security Act (42 U.S.C. 1396a(a)(13)(D)), as inserted by section 9505(c)(1)(C) of COBRA and as amended and redesignated by paragraphs (2) and (3) of section 9509(a) of COBRA, is amended by adding “and” at the end.

(2) **CAPITALIZATION.**—Section 1903(m)(2)(F) of the Social Security Act (42 U.S.C. 1396b(m)(2)(F)), as amended by section 9517(a)(2)(A) of COBRA, is amended by striking out “in the case” and inserting in lieu thereof “In the case”.

(3) **CASE-MANAGEMENT SERVICES.**—(A) Section 1905(a) of the Social Security Act (42 U.S.C. 1395d(a)) is amended—

- (i) by striking out “and” at the end of paragraph (18),
- (ii) by redesignating paragraph (19) as paragraph (20), and
- (iii) by inserting after paragraph (18) the following new paragraph:

“(19) case-management services (as defined in section 1915(g)(2)); and”.

(B) Section 1902(j) of the Social Security Act (42 U.S.C. 1396a(j)), as amended by section 9505(d)(1) of COBRA, is amended by striking out “(19)” and inserting in lieu thereof “(20)”.

(C) Section 1902(a)(10)(C)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(C)(iv)), as amended by section 9505(d)(2) of COBRA, is amended by striking out “through (18)” and inserting in lieu thereof “through (19)”.

(4) **HEALTH INSURING ORGANIZATIONS.**—Section 9517(c)(2) of COBRA is amended—

(A) in subparagraph (A), by adding at the end the following: “For purposes of this paragraph, a health insuring organization is not considered to be operational until the date on which it first enrolls patients.”;

(B) in subparagraph (B), by striking out “(iv)” and inserting in lieu thereof “(vi)”;

(C) by adding at the end the following new subparagraph:

“(C) In the case of the Hartford Health Network, Inc., clauses (ii) and (vi) of section 1903(m)(2)(A) of the Social Security Act shall not apply during the period for which a waiver by the Secretary of Health and Human Services, under section 1915(b) of such Act, of certain requirements of section 1902 of such Act is in effect (pursuant to a request for a waiver under section 1915(b) of such Act submitted before January 1, 1986).”

(5) REFERENCES TO OTHER PROVISIONS.—Section 1920(a) of the Social Security Act (42 U.S.C. 1396s(a)), as added by section 9526 of COBRA, is amended—

(A) in paragraph (1)—

(i) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D), respectively, and

(ii) by inserting after “—(A)” the following: “Section 402(a)(32) of this Act (relating to individuals who are deemed recipients of aid but for whom a payment is not made).”

(B) in paragraph (2)—

(i) by inserting “(A)” after the dash, and

(ii) by adding at the end the following new subparagraph:

“(B) Section 1634(b) of this Act (relating to preservation of benefit status for disabled widows and widowers who lost SSI benefits because of 1983 changes in actuarial reduction formula).”; and

(C) in paragraph (3), by striking out “Section 473(b)” and inserting in lieu thereof “Sections 472(h) and 473(b)”.

(6) REFERENCE CORRECTION.—Section 9528(a) of COBRA is amended by striking out “1101(a)(8)(P)” and inserting in lieu thereof “1101(a)(8)(B)”.

(7) INDENTATION.—Section 1902(a)(10)(A)(ii), of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by sections 9505(b)(2) and 9529(b)(1) of COBRA, is amended—

(A) by indenting subclause (VII) two additional ems so as to align its left margin with the left margins of subclauses (I) through (VI) of such section, and

(B) by indenting subclause (VIII) (and each of its subdivisions) four additional ems so as to align its left margin with the left margins of subclauses (I) through (VI) of such section.

(d) AMENDMENTS RELATING TO CONTINUATION OF EMPLOYER-BASED HEALTH INSURANCE COVERAGE.—

(1) EFFECT OF MODIFICATIONS TO PLAN COVERAGE PROVISIONS.—

(A) IRC AMENDMENT.—Subparagraph (A) of section 162(k)(2) (relating to type of benefit coverage) is amended by adding at the end the following: “If coverage under the plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this subsection in connection with such group.”

(B) ERISA AMENDMENT.—Paragraph (1) of section 602 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(1); 100 Stat. 228) is amended by adding at the

“(B) SPOUSE MAY WAIVE PROVISIONS OF PARAGRAPH (2).—In the case of any participant described in paragraph (2), the surviving spouse of such participant may waive the provisions of paragraph (2). Such waiver shall be made on or before the close of the second plan year to which the amendments made by section 103 of this Act apply. Such a waiver shall not be treated as a transfer of property for purposes of chapter 12 of the Internal Revenue Code of 1954 and shall not be treated as an assignment or alienation for purposes of section 401(a)(13) of the Internal Revenue Code of 1954 or section 206(d) of the Employee Retirement Income Security Act of 1974.”

(B) Section 2503 is amended by adding at the end thereof the following new subsection:

“(f) WAIVER OF CERTAIN PENSION RIGHTS.—If any individual waives, before the death of a participant, any survivor benefit, or right to such benefit, under section 401(a)(11) or 417, such waiver shall not be treated as a transfer of property by gift for purposes of this chapter.”

(2) Subparagraph (A) of section 303(e)(2) of the Retirement Equity Act of 1984 (relating to treatment of certain participants who perform services on or after January 1, 1976) is amended by striking out “in the first plan year” and inserting in lieu thereof “in any plan year”.

(3) Paragraph (2) of section 303(c) of the Retirement Equity Act is amended by adding at the end thereof the following new sentence: “In the case of a profit-sharing or stock bonus plan to which this paragraph applies, the plan shall be treated as meeting the requirements of the amendments made by sections 103 and 203 with respect to any participant if the plan made a distribution in a form other than a life annuity to the surviving spouse of the participant of such participant’s nonforfeitable benefit.”

(i) TECHNICAL AMENDMENT TO SECTION 408(d) OF ERISA.—

(1) Subsection (d) of section 408 of the Employee Retirement Income Security Act of 1974 is amended by striking out “(a),”.

(2) The amendment made by paragraph (1) shall apply to transactions after the date of the enactment of this Act.

(j) **EFFECTIVE DATE.—**Except as otherwise provided in this section, any amendment made by this section shall take effect as if included in the provision of the Retirement Equity Act of 1984 to which such amendment relates.

CHAPTER 3—AMENDMENT RELATED TO THE CHILD SUPPORT ENFORCEMENT AMENDMENTS OF 1984

SEC. 1899. AMENDMENT RELATED TO THE CHILD SUPPORT ENFORCEMENT AMENDMENTS OF 1984.

(a) **IN GENERAL.—**Section 457(b)(3) of the Social Security Act is amended by inserting “or administrative” after “court”.

(b) **EFFECTIVE DATE.—**The amendment made by this section shall become effective on the date of the enactment of this Act

(70) The item relating to tax credit employee stock ownership plans in the table of sections for subpart A of part I of subchapter D of chapter 1 is amended to read as follows:

“Sec. 409. Qualifications for tax credit employee stock ownership plans.”

(71) The table of sections for subpart C of part II of subchapter E of chapter 1 is amended in the item relating to section 467 by inserting “the” before “use”.

(72) The table of subparts for part V of subchapter P of chapter 1 is amended by inserting “on bonds” after “discount” in the item relating to subpart B.

(73) The table of sections for subchapter B of chapter 3 is amended by striking out the item relating to section 1461 and inserting in lieu thereof the following:

“Sec. 1461. Liability for withheld tax.”

(74) The table of sections for subchapter G of chapter 32 is amended by striking out “references” in the item relating to section 4227 and inserting in lieu thereof “reference”.

(75) The table of sections for chapter 43 is amended by—

(A) inserting “section” before “403(b)” in the item relating to section 4973, and

(B) striking out “and allocations” in the item relating to section 4978.

Approved October 22, 1986.

LEGISLATIVE HISTORY—H.R. 3838:

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Oct. 22, Presidential remarks.

TAX REFORM ACT OF 1985

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ON

H.R. 3838

together with

DISSENTING AND ADDITIONAL DISSENTING VIEWS



DECEMBER 7, 1985.—Committed to the Committee of the Whole House on
the State of the Union and ordered to be printed

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TAX REFORM ACT OF 1985

DECEMBER 7, 1985.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. ROSTENKOWSKI, from the Committee on Ways and Means,
submitted the following

REPORT

[To accompany H.R. 3838]

together with

DISSENTING AND ADDITIONAL DISSENTING VIEWS

The Committee on Ways and Means, to whom was referred the bill (H.R. 3838) to reform the internal revenue laws of the United States, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

I. LEGISLATIVE BACKGROUND

This bill, H.R. 3838, was introduced and ordered favorably reported on December 3, 1985, after almost a year-long comprehensive review in the 99th Congress by the committee and subcommittees in public hearings and markup consideration. This has been the most extensive review of internal revenue laws since enactment of the 1954 Code. In light of this fact, this tax reform bill redesignates the Internal Revenue Code of 1954 as the Internal Revenue Code of 1985.

Committee Hearings

The full committee held 30 days of public hearings on comprehensive tax reform proposals. The committee began public hearings on comprehensive tax reform proposals on February 27, 1985. Committee hearings on tax reform issues continued on March 26; May 30; June 4, 5, 7, 11-14, 17, 18, 20, 24-27; and July 8-12, 17, 19, 22, 25, 26, 29-31. A committee hearing also was held on May 16, on proposed technical corrections to the Deficit Reduction Act of 1984 (H.R. 1800) and to the Retirement Equity Act of 1984 (H.R. 2100).

Included in the committee's tax reform hearing consideration this year was the President's tax reform proposal made in May 1985 ("The President's Tax Reform Proposals to the Congress for Fairness, Growth, and Simplicity").

Subcommittee Hearings

Several Subcommittee hearings were held during 1985 that relate to subject matters included in H.R. 3838.

Subcommittee on Select Revenue Measures.—The Select Revenue Measures Subcommittee held hearings on the following areas:

March 19—Targeted jobs tax credit

April 1, 2, 16—Acquisitions and mergers (with Oversight Subcommittee)

April 25—Attorney's fees

May 22—Carryover of net operating losses (NOLs)

June 6—Tax burdens of low-income wage earners

Subcommittee on Oversight.—The Oversight Subcommittee held hearings on the following areas:

June 21—IRS taxpayer refund delays

July 18, September 5, 6—Retirement income security (with Social Security Subcommittee)

August 1—Tax-exempt multifamily housing bonds

September 19—Tax refund offsets to collect non-tax Federal debts

September 20—High-income taxpayers and partnership tax issues

Committee Markup

The committee conducted 26 days of markup on the tax reform bill: beginning on September 18; continuing on September 26, 30, October 1-4, 7-9, 11, 15, 23, 25-27, November 6, 15-17, 19-23; and concluding on December 3 when the tax reform bill, H.R. 3838, was introduced and ordered favorably reported. There was also a committee markup on technical corrections to 1984 tax legislation on September 27, which is included as a separate title XV to this bill.

II. SUMMARY OF THE BILL

Title I. Individual Income Tax Provisions

A. Basic Rate Structure

1. Rate reductions

The bill provides a new 4-bracket tax rate schedule based on taxable income, which will become effective on July 1, 1986. The Secretary of the Treasury is instructed to prepare blended tax schedules for 1986 tax returns which will incorporate half of the present law structure (as indexed for inflation) and half of the new tax rate structure. The new tax rate structure, which will be fully effective on January 1, 1987, is shown below.

Tax rates (%)	Taxable income			
	Married couples & surviving spouses	Heads of households	Unmarried individuals	Married individuals filing separately
15.....	Not over \$22,500	Not over \$16,000	Not over \$12,500	Not over \$11,250
25.....	22,500-43,000	16,000-34,000	12,500-30,000	11,250-21,500
35.....	43,000-100,000	34,000-75,000	30,000-60,000	21,500-50,000
38.....	Over 100,000	Over 75,000	Over 60,000	Over 50,000

The taxable income amounts in the rate schedules is indexed for inflation beginning in 1987.

2. Increase in standard deduction

The standard deduction replaces the zero bracket amount. Effective in 1987, the standard deduction amounts are \$4,800 for joint returns of married couples and for surviving spouses, \$4,200 for heads of households, \$2,950 for unmarried individuals, and \$2,400 for married individuals filing separate returns. These amounts are indexed for inflation beginning in 1988.

An additional standard deduction amount of \$600 is allowed for an elderly or blind individual. For these taxpayers only, the new standard deduction amount and the additional \$600 standard deduction amount are effective on January 1, 1986.

For all individual taxpayers other than elderly or blind individuals, the standard deduction amounts for 1986 are \$3,670 for joint returns, \$2,480 for heads of households and single persons, and \$1,835 for married individuals filing separately.

Individuals who itemize deductions will reduce their total itemized deductions by \$500 times the number of personal exemptions claimed.

3. Increase in personal exemption

The personal exemption is raised to \$2,000 for each individual, individual's spouse, and dependent, effective January 1, 1986. (The additional exemption under present law for a blind or elderly individual is repealed.) The personal exemption amount is indexed for inflation beginning in 1987.

4. Two-earner deduction

The deduction for two-earner married couples is repealed after December 31, 1985. Adjustments made in the standard deduction for married couples filing joint returns and in the relationship of the rate schedules for unmarried individuals and married couples filing joint returns compensate for the repeal of this provision.

B. Individual Tax Credits

1. Earned income credit

Currently, an eligible individual is allowed a refundable income tax credit equal to 11 percent of the first \$5,000 of earned income, for a maximum credit of \$550. The maximum allowable credit is phased down, however, as adjusted gross income (or, if greater, earned income) rises above \$6,500. Also, the credit is not allowed for taxpayers with adjusted gross income (AGI) or, if greater, earned income over \$10,000. Currently, the credit is not adjusted for inflation.

The bill increases the maximum allowable credit to 14 percent of the first \$5,000 of earned income (for a maximum credit of \$700), for taxable years beginning on or after January 1, 1986. The phase-out levels for 1986 are adjusted so that the credit phases out between \$6,500 and \$13,500 of AGI. For taxable years beginning on or after January 1, 1987, the phaseout of the credit begins at \$9,000 of AGI; it is totally phased out at \$16,000 of AGI. Also, the maximum amount of the credit and the phaseout income levels are adjusted for inflation.

2. Repeal of political contributions credit

The tax credit allowed to individuals under present law for one-half the amount of contributions to political candidates and certain political campaign organizations, up to a maximum of \$50 (\$100 on a joint return), is repealed. The repeal is effective for taxable years beginning after December 31, 1985.

C. Provisions Related to Exclusions

1. Limit on exclusion for child care assistance

The bill limits the exclusion for employer-provided child care assistance to \$5,000 a year (\$2,500 in the case of a married individual filing separately), effective for taxable years beginning after December 31, 1985.

2. Unemployment compensation benefits

Under present law, a portion of unemployment compensation benefits is includible in gross income if the sum of the recipient's benefits and adjusted gross income exceeds specified amounts. The

bill provides that all unemployment compensation benefits are uncludible in gross income, for taxable years beginning after December 31, 1985.

3. Scholarships and fellowships

The bill limits the exclusion for degree candidates to the amount of a scholarship or fellowship grant required to be used for tuition and fees, books, supplies, and equipment required for courses. The bill repeals the exclusion for grants received by nondegree candidates, but does not affect whether their unreimbursed educational expenses may be deductible as trade or business expenses. The bill also provides that the exclusion does not apply to any portion of amounts received as a scholarship or a tuition reduction which represents payment for teaching, research, or other services required as a condition of receiving the grant. The bill repeals the present-law exclusion for certain Federal grants where the recipient is required to perform future services as a Federal employee. The provision is effective for scholarships and fellowships granted after September 25, 1985.

4. Exclusion for prizes and awards

The exclusion for certain prizes and awards is repealed, except where the winner assigns the award to charity (see also the description above of the scholarship exclusion). Awards by employers to employees are includible in income unless qualifying for the present-law exclusion for de minimis items (such as certain traditional retirement gifts). The provision applies to taxable years beginning after December 31, 1985.

D. Individual Deductions

1. Employee expenses and miscellaneous itemized deductions

A one-percent floor is placed under itemized deductions for miscellaneous employee, investment, and certain other expenses, and nonreimbursed employee travel and other expenses that presently are deductible "above-the-line" are included in the miscellaneous itemized deduction. The provision is effective for taxable years beginning after December 31, 1985.

2. Charitable contribution deduction for nonitemizers

The bill makes permanent the deduction for charitable contributions made by individuals who do not itemize deductions. The bill modifies the deduction by providing that for taxable years beginning after 1985, the deduction is subject to a \$100 floor.

3. Adoption expenses

Currently, an individual is allowed an itemized deduction for up to \$1,500 of expenses incurred in the adoption of certain handicapped ("special needs") children. The bill repeals this deduction for taxable years after December 31, 1986, and modifies the Adoption Assistance Program of Title IV-E of the Social Security Act to provide assistance through that program for such adoption expenses (see also Title XIV, item 7.)

TECHNICAL CORRECTIONS IN OTHER PROGRAMS AFFECTED BY THE
DEFICIT REDUCTION ACT OF 1984

A. Technical Corrections to Social Security Act Programs

1. Special Social Security Treatment for Church Employees (sec. 1585 of the bill, sec. 2603 of the Act, secs. 1402 and 3121 of the Code and sec. 211 of the Social Security Act)

a. Application to members of certain religious faiths

Present Law

The Act allows a church or qualifying church-controlled organization to make a one-time election to exclude from the definition of employment, for purposes of FICA taxes, services performed in the employ of the church or organization. If an election is made to exclude services for FICA purposes, the employee is treated similarly to a self-employed person with respect to those services. Thus, the employee is liable for self-employment ("SECA") taxes on remuneration for such services. The amount of remuneration on which an employee of an electing organization is liable for SECA tax is generally the same as the amount which would have been subject to FICA tax in the absence of an election.

Under section 1402(g) of the Code, an exemption from SECA taxes is provided for self-employed members of a religious sect (e.g., the Amish) who are adherents of established tenets or teachings of that sect, by reason of which such individuals are conscientiously opposed to public or private death, retirement, or medical insurance (including social security). This exemption is not available to employees. This exemption is granted only upon application by the individual, which must include evidence of the sect's tenets or teachings and of the individual's adherence to them. To obtain an exemption, the individual must waive all social security benefits.

Explanation of Provision

The bill makes clear that the exception from SECA taxes for members of certain religious faiths (sec. 1402(g)) is not available for services with respect to which SECA tax is due as a result of an election under the Act. Thus, if a member of a religious faith covered by the sec. 1402(g) exception is an employee of a church or church-controlled organization, and that church or organization elects to treat the employee as self-employed for FICA tax purposes, the employee cannot also claim a section 1402(g) exception from SECA taxes with respect to those services. This provision prevents the combination of an election under the Act, and a section 1402(g) exception, from resulting in an avoidance of any employment taxes on the services performed for the electing organization. This is consistent with the general principle that the tax for serv-

ices covered by an election should be determined (to the extent possible) as it would be under FICA, for which the section 1402(g) exception would be unavailable. The provision does not affect the individual's ability to claim a section 1402(g) exception with respect to other services not covered by an election under the Act.

b. Computation of income subject to SECA tax

Present Law

Under the Act, the remuneration on which the employee of an electing church or organization is liable for SECA tax generally is the same as the amount which would have been subject to FICA tax if that individual had continued to be treated as an employee. Thus, trade or business expenses are not subtracted in computing self-employment income (reimbursed business expenses are not included in self-employment income, however), and the \$400 threshold generally applicable to self-employment income does not apply. Similarly, a \$100 threshold (per employer) for a taxable year applies in determining whether remuneration for services covered by an election is subject to SECA tax. However, after 1989 these employees will be eligible for a deduction, in computing SECA taxes, for the product of net earnings from self-employment and one-half of the SECA rate.

Explanation of Provision

The bill provides several changes to insure that church employee income will be determined, as far as possible, using FICA principles, and that the taxation of other self-employment income will not be affected by an election. Specifically, the bill specifies that the SECA tax base for services covered by an election is to be computed in a separate "basket" from the tax base for other self-employment income. Thus, church employee income is not reduced by any deduction, while other income and deductions are not affected by items attributable to church employee income.¹² (This rule does not apply to the deduction for the product of all net self-employment earnings and one-half the SECA tax rate, beginning after 1989). Additionally, the \$100 threshold for taxing church employee income, and the \$400 threshold applicable to other self-employment income, are separately applied under the bill (i.e., church employee income does not count toward the general \$400 threshold).

This provision is effective only for remuneration paid or derived in taxable years beginning on or after January 1, 1985.

c. Voluntary revocation of election

Present Law

Under the Act, a church or organization must make an election to treat services performed for the church or organization as subject to SECA (rather than FICA) taxes before its first quarterly employment tax return is due, or if later, 90 days after July 18, 1984.

¹² The "optional" method of computing self-employment income would apply only to non-church employee income.

Once made, that election may not be revoked by the church or organization. However, an election is to be permanently revoked by the Treasury Department if the electing church or organization fails to provide required information regarding its employees for a period of two years or more and, upon request by the Treasury Department, fails to furnish previously unfurnished information for the period covered by the election. (This information is required in order to monitor compliance with the provisions of the Act.) This rule could allow an electing church or organization effectively to revoke its election by failing to provide the required information.

Explanation of Provision

The bill allows a church or organization to revoke an election under regulations to be prescribed by the Treasury Department. The Treasury Department would continue to be permitted to revoke an election for failure to provide required information, as under present law. A church or organization which revokes an election (or for which the election is revoked) could not make another election, because the time for making such an election would have lapsed.

2. Amendments to the Medicare Program

a. Corrections relating to enrollment and premium penalty under the working aged provision (sec. 1586 of the bill and secs. 1839(b) and 1837(i) of the Social Security Act)

Present Law

Under current law, employers are required to offer to employees age 65 through 69, and employees with spouses age 65 through 69, the same health benefit plan they offer to their other employees. Where the employee or spouse choose the employer plan, medicare becomes the secondary payor.

Aged employees or aged spouses may wish to delay their enrollment in medicare because the coverage may be duplicative of the employer plan. However, persons who enroll in part A or part B late are subject to a penalty. The monthly premium is increased by 10 percent for each 12 months that an individual delays enrollment in medicare beyond his or her initial enrollment period at age 65. In addition, after the initial enrollment period, a person may enroll in medicare only during the annual enrollment period in January, February, and March.

The Deficit Reduction Act (P.L. 98-369) created a special enrollment period and waived the enrollment penalty for the working aged (and aged spouses) under certain circumstances. DEFRA provided a special enrollment period for persons who did not elect medicare because of coverage at the time under an employer plan and who lose such employer coverage or turn age 70. However, there is an anomaly in the law in that individuals who did not enroll during an initial enrollment period (even though the reason for nonenrollment may have been coverage under the employer plan) have only one special enrollment period, while persons who enrolled in the initial enrollment period, but later terminated coverage when covered under an employer plan, may have more than one special enrollment period.

DEFRA also forgives the premium penalty in certain cases. The provision currently forgives the penalty for those months in which an individual is enrolled in an employer group health plan related to the current employment of the individual (or the individual's spouse), is under 70 years of age, and is entitled to medicare part A (that is, meets the eligibility requirements and has filed an application for part A).

Explanation of Provision

The bill corrects the anomaly in the special enrollment provision which permits only one special enrollment period for an individual who was covered under an employer plan during his initial enrollment period and therefore did not enroll during such period. The

VII. VOTE OF THE COMMITTEE AND OTHER MATTERS TO BE DISCUSSED UNDER HOUSE RULES

A. Vote of the Committee

In compliance with clause 1(1)(2)(B) of Rule XI of the House of Representatives, the following statement is made concerning the vote of the committee on the motion to report H.R. 3838. The bill was ordered favorably reported by a roll call vote of 28 ayes and 8 noes.

B. Other Matters

In compliance with clauses (2)(1)(3) and 2(1)(4) of Rule XI of the Rules of the House of Representatives, the following statements are made with respect to the committee action on H.R. 3838.

Oversight Findings

With respect to subdivision (A) of clause (2)(1)(3) (relating to oversight findings), the committee advises that it was a result of the committee's comprehensive review of tax reform proposals during the past year (see legislative background in Part I of this report regarding the hearing and markup schedule of the committee and subcommittees relating to tax reform) that the committee concluded it is appropriate to report a comprehensive tax reform bill. (See also Part II of this report for more details on the overall reasons for the need to revise and reform the Internal Revenue Code.)

Tax Expenditures

With respect to subdivision (B) of clause 2(1)(3), the committee states that the changes made by the bill as reported involve a net decrease in tax expenditures (individual and corporate income tax provisions) for fiscal years 1986-1990, of \$327 billion, as follows:

NET DECREASE IN TAX EXPENDITURES

[Fiscal years (billions of dollars)]

	1986	1987	1988	1989	1990
Individual income tax.....	6.1	20.9	22.0	26.6	31.8
Corporate income tax	19.5	36.8	47.1	53.3	62.9
Net changes in tax expenditures ¹	25.6	57.8	69.1	79.9	94.7

¹These estimates are based on the new tax rate schedules for the bill for individuals and corporations, as included in Table IV-2 in Part IV of this report. Changes in the basic tax rate structure (individual tax rates, personal exemptions, and standard deduction, and basic corporate tax rate) are not considered as affecting tax expenditures. The graduated tax rate for small corporations is counted as a tax expenditure. Changes in excise taxes and estate and gift taxes are not considered to involve tax expenditures under the present definition of tax expenditures.

New Budget Authority

With respect to subdivision (B) of clause 2(1)(3), the committee states that the changes made by the bill as reported involve increased budget authority (with respect to the increase in the refundable earned income credit) of \$40 million in fiscal year 1986, \$1,177 million in fiscal year 1987, \$2,025 million in fiscal year 1988, \$2,275 million in fiscal year 1989, and \$2,555 million in fiscal year 1990. Also, the bill involves budget outlays of less than \$5 million per year for the attorney's fees provision and amounts relating to the new adoption assistance program authorized by section 1407 of the bill, similar to the revenue gain from the repeal of the adoption expense deduction under section 134 of the bill.

Congressional Budget Office Estimates

With respect to subdivision (C) of clause 2 (1)(3), the committee advises that no statement has been received from the Director of the Congressional Budget Office concerning the provisions of this bill as reported.

Oversight by Committee on Government Operations

With respect to subdivision (D) of clause 2(1)(3), the committee advises that no oversight findings or recommendations have been submitted by the Committee on Government Operations regarding the subject matter of the bill.

Inflationary Impact

In compliance with clause 2(1)(4), the committee states that the provisions of the bill are not expected to produce any significant change in the general price level. The individual income tax provisions reduce the overall burden of taxes on individuals eliminate about 6 million lower income filers from income tax liability, and reduce the marginal tax rates, thereby increasing the after-tax return to additional work effort and increased productivity. Business activity is affected by a number of interrelated changes which include lower corporate income tax rates and a considerably broader corporate income tax base. Although some businesses may be affected adversely, the general nature of these tax law changes is to eliminate or reduce special or narrow tax incentives that have favored specific business activity or industries. These tax changes will establish a substantially more equal competitive field for all businesses so that business economic decisions will be made in terms of their inherent profitability instead of primarily on the basis of tax advantages.

TAX REFORM ACT OF 1986

REPORT

OF THE

**COMMITTEE ON FINANCE
UNITED STATES SENATE**

TO ACCOMPANY

H.R. 3838

together with

ADDITIONAL VIEWS

[Including cost estimate of the Congressional Budget Office]



MAY 29, 1986.—Ordered to be printed

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TAX REFORM ACT OF 1986

MAY 29 (legislative day, MAY 19), 1985—Ordered to be printed

Mr. PACKWOOD, from the Committee on Finance,
submitted the following

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany H.R. 3838]

[Including cost estimate of the Congressional Budget Office]

The Committee on Finance, to which was referred the bill (H.R. 3838) to reform the internal revenue laws of the United States, having considered the same, reports favorably thereon with an amendment in the nature of a substitute to the text and an amendment to the title, and recommends that the bill as amended do pass.

I. LEGISLATIVE BACKGROUND

H.R. 3838 was passed by the House of Representatives on December 17, 1985. It was ordered favorably reported by the Committee on Finance on May 6, 1986, with an amendment in the nature of a substitute, after almost a year-long comprehensive review in the 99th Congress by the Committee on Finance and subcommittees in public hearings and markup consideration. This has been the most extensive review of internal revenue laws since enactment of the 1954 Code.

Committee Hearings

The full committee held 36 days of public hearings on comprehensive tax reform proposals in 1985-1986. The committee began public hearings on comprehensive tax reform proposals on May 9,

1985. In 1985, committee hearings on tax reform issues were held on June 11-13, 17-20, 25-27; July 9-11, 16-19, 24-25; September 24 and 26; and October 1-4 and 9-10. In 1986, committee hearings were held on January 29-30; February 3-16; March 4; and April 21.

Included in the committee's tax reform hearing consideration this past year was the President's tax reform proposal made in May 1985 ("The President's Tax Reform Proposals to the Congress for Fairness, Growth, and Simplicity").

Subcommittee Hearings

Several Subcommittee hearings were held during 1985 and 1986 that relate to subject matters included in H.R. 3838, as amended by the Committee on Finance.

Subcommittee on Savings, Pensions, and Investment Policy.—The Savings, Pensions, and Investment Policy Subcommittee held hearings on the following areas:

September 9, 1985—Post-retirement health benefits

November 22, 1985—Targeted jobs tax credit extension

January 28, 1986—Retirement Income Policy Act

Subcommittee on Energy and Agricultural Taxation.—The Energy and Agricultural Taxation Subcommittee held a hearing on the following area:

June 21, 1985—Impact of taxation on energy policy

Subcommittee on Health.—The Health Subcommittee held a hearing on the following area:

September 9, 1985—Asbestos-related disease trust fund

Subcommittee on Taxation and Debt Management.—The Taxation and Debt Management Subcommittee held a hearing on the following area:

January 31, 1986—Mortgage-backed securities

Committee Markup

The committee conducted 17 days of markup on the tax reform bill: beginning on March 19, 1986; continuing on March 24-26, April 8-10, 14-18, 22, 24, 28, and May 5; and concluding on May 6, when the tax reform bill, H.R. 3838, as amended,* was ordered favorably reported by a unanimous vote (20-0).

* References in this Report to "the bill" are to the committee amendment to H.R. 3838, which is reported in the nature of a substitute to H.R. 3838 as passed by the House of Representatives.

II. GENERAL REASONS FOR THE BILL

Overview

The committee bill represents one of the most fundamental reforms of the Federal income tax system since its introduction in 1913. After nearly a year of hearings, the committee concluded that only the most thorough reform could assure a simpler, fairer, and more efficient tax system which could regain the trust of the American people.

The committee bill sets forth a number of sweeping changes to the present system. First, the committee desires a simpler tax system for individuals. The bill provides just two individual income tax rates—15 percent and 27 percent—to replace more than a dozen tax rates in each of the present-law rate schedules which extend up to 50 percent. Significant increases in the standard deduction and restrictions on certain personal deductions will provide further simplicity by greatly reducing the number of taxpayers who would itemize their deductions.

Second, the committee desires a fairer tax system. It is difficult for the committee to find fairness in a tax system that allows some high-income individuals to pay far lower rates of tax than other, less affluent individuals. The committee bill provides strict new limitations on the use of losses from passive investments to shelter other types of income and expands the minimum tax to prevent these tax inequities in the future. The committee bill also provides significant reductions in the tax burden of the working poor and removes six million low-income individuals from the tax roll.

Third, the committee seeks a more efficient tax system. The current tax system intrudes at nearly every level of decision-making by businesses and consumers. The sharp reductions in personal and corporate tax rates and the elimination of many preferences will directly remove or lessen tax considerations in business and consumption decisions. Businesses will be able to compete on a more equal basis, and business winners will be determined more by serving the changing needs of a dynamic economy, and less by reaping the subsidies provided by the tax code.

Simplicity

The present tax system is far from simple. April 15 is a date feared by many individuals not because they are unwilling to provide the revenues needed for necessary government activities, but because of the recordkeeping, paperwork, and computations necessitated by tax filing. Many taxpayers feel they must rely on paid tax preparers in order to calculate accurately their tax liability. The complexity faced by other taxpayers has helped spawn a thriving tax shelter industry whose sole purpose is to reduce tax liability by making use of special tax provisions and by engaging in so-

phisticated financial arrangements. The cost of complying with all of the requirements of the income tax is estimated to total 5 to 10 percent of the tax actually paid. Simplification of the tax code is, itself, a form of tax reduction.

The committee bill will reduce significantly the complexity of the tax code for most Americans. There will be only two individual tax brackets, and over 80 percent of all individual taxpayers will pay no tax or at a marginal rate no higher than 15 percent.

As a result of significant increases in the standard deduction, the number of itemizers is estimated to decline by one-third under the committee bill. These taxpayers who use the standard deduction rather than itemizing will be freed from much of the recordkeeping, paperwork, and computations that currently are required.

Other individuals who presently expend a great amount of time and resources to find investments that reduce their tax liability also will benefit from tax simplification. Currently, many of these investments yield no current economic profit, but are valuable for the paper losses they create. With the significant rate reductions achieved by this bill, many taxpayers will find such investments unnecessary, and will choose less complex and more productive investments.

Some taxpayers who attempt to use various preferences to reduce their tax liability significantly may find that the bill does not simplify the tax filing process for them as much as for other individuals. In part, the complexity of the tax system for these individuals is needed to measure accurately their income and to ensure that these individuals pay a rate of tax appropriate for their income.

Fairness

A primary goal of the committee is to provide a tax system that ensures that individuals with similar incomes pay similar amounts of tax. The ability of some individuals to reduce their tax liability excessively leads to a direct erosion of the tax base, requiring higher tax rates. Other individuals unable to take advantage of tax shelters may lose confidence in the tax system and may respond by seeking to evade their tax liability.

The committee has adopted a significant new provision which directly restricts the use of tax shelter losses to offset unrelated income. Further, a strengthened minimum tax prevents the elimination of substantial income tax liability through the excessive use of preferences. Given these restrictions and the elimination of other preferences, the dramatic reduction in the top tax rate from 50 percent to 27 percent can be achieved while maintaining the distribution of the tax burden.

The committee believes that as a result of the large reductions in tax rates, it is no longer necessary to provide a lower rate for capital gains income of individuals. Eliminating the preferential treatment of capital gains income, and thereby eliminating the incentive to recharacterize certain income in order to qualify for capital gains treatment, will eliminate the abuse of this provision and greatly reduce the complexity of the tax system for many individuals.

The committee bill retains the most widely utilized itemized deductions, including deductions for home mortgage interest, State and local income taxes, real estate and personal property taxes, charitable contributions, casualty and theft losses, and medical expenses (above an increased floor). Other deductions which benefit a limited number of taxpayers, add complexity to tax filing, or are subject to abuse are restricted. For example, the requirements for deducting business meals are tightened and only 80 percent of business meals and entertainment expenses are deductible under the bill. Certain abuses such as the deduction for attending investment seminars and for "educational" travel costs are eliminated. These expenditures differ little from other personal consumption expenditures, which generally are not deductible.

The committee bill disallows the itemized deductions for State and local sales taxes and interest deductions for other than a first or second home mortgage. The committee believes these deductions introduce unnecessary complexity and encourage consumption at the expense of savings.

Certain items of compensation that are similar to taxable compensation are no longer excluded from income under the bill. For example, the partial exclusion for unemployment compensation is repealed, and certain prizes and awards are taxable. The ability of high-income families to take advantage of the graduated rate structure by transferring investment property to their minor children and thus sheltering their investment earnings at their children's lower tax rates also is restricted.

The committee bill makes numerous changes to increase employee eligibility for pension benefits. The bill expands the rules requiring coverage of a broad group of employees under an employer-maintained retirement plan, reduces from 10 years to 5 years the maximum time an employee must work for a given employer before becoming vested, and eliminates the ability of employers to offset completely the pension benefits of low-paid workers by the amount of their social security benefits. The committee bill also reduces the limitations on annual elective deferrals to qualified cash or deferred arrangements (sec. 401(k) plans), and provides tighter nondiscrimination tests to ensure that such plans do not disproportionately benefit highly compensated employees.

The committee believes that the present tax treatment of individual retirement accounts (IRAs) is unnecessarily generous for individuals who participate in other tax-favored retirement arrangements, and the bill eliminates the deduction for contributions to an IRA for such individuals. The bill permits these individuals, however, to make nondeductible contributions to an IRA and to defer taxes on the earnings of these contributions. The committee believes that the lower tax rates provided by the bill, which will themselves stimulate additional work effort and saving, eliminate the need for this special deduction for these individuals. To ensure universal availability of tax-favored retirement arrangements, the bill retains the present-law deduction for individuals unable to participate in other plans.

In addition to ensuring that high-income taxpayers pay their share of the Federal tax burden, the committee bill provides tax relief to low-income wage earners. To achieve this goal, the com-

mittee bill substantially increases the standard deduction (the present-law zero bracket amount) and nearly doubles the personal exemption to \$2,000. Together with the greatly expanded earned income credit, these provisions will relieve approximately six million low-income individuals from tax liability and will ensure that no families below the poverty level will have Federal income tax liability. The child care credit is preserved to assist working parents with their dependent care expenses.

The elderly and blind also receive tax relief under the bill. Although they would no longer qualify for an extra personal exemption, a special \$600 standard deduction, effective for 1987, is provided for these taxpayers in addition to the increased standard deduction and personal exemption provided for all taxpayers. The present-law credit for elderly individuals and for individuals who are permanently and totally disabled also is retained.

Tax fairness also requires that corporate taxpayers pay amounts of tax appropriate for their level of earnings. The committee finds it unjustifiable for some corporations to report large earnings and pay significant dividends to their shareholders, yet pay little or no taxes on that income to the government. The committee has designed a strong alternative minimum tax for corporations, based on a broad tax base, to prevent corporations from significantly reducing their tax liability. A unique feature of this alternative minimum tax is the inclusion of a corporation's book income in the tax base used for this computation.

The committee bill makes several accounting changes to provide more accurate matching between the recognition of income and deductions for expenditures related to this income. Use of the installment method is restricted and certain costs of inventory and self-constructed assets are capitalized under the bill. Similarly, the committee bill alters the taxation of property and casualty insurance companies to account better for timing differences to measure income more accurately.

The taxation of foreign income also is modified to restrict opportunities to use passive financial transactions to reduce tax liability on U.S. income, while not hindering the international competitiveness of U.S. firms. In addition, the bill provides more equitable taxation of foreign investment in the United States.

Together with other changes made by the bill, the aggregate corporate tax liability is estimated to increase by approximately \$100 billion between fiscal years 1986 and 1991, while individual taxes are reduced by a similar amount. Even with these changes, the share of total income tax receipts paid by corporations will remain below pre-1980 levels.

The committee also believes it is important to maintain the trust of honest taxpayers in the tax system by ensuring that other taxpayers cannot illegally evade their tax liability. The committee bill provides for significant increases in the Internal Revenue Service budget for agents, audits, and the modernization of compliance systems. These budget increases are made possible by the establishment of a unique IRS trust fund, funded through penalties for non-compliance and interest on underpayments of tax.

Efficiency

The committee's most important steps in promoting the efficiency of the economy and in reducing the interference of the tax system are the dramatic reductions in personal and corporate tax rates. Lower marginal tax rates stimulate work effort and saving by leaving more of each additional dollar earned in the hands of the taxpayer. Further, lower tax rates reduce the value of tax deductions, causing investment and consumption decisions to be chosen more on the basis of their economic merits, and less on the value of the tax benefits associated with them.

The present Federal tax system contains a number of tax preferences, which have not satisfactorily served the purposes for which they were designed. In the past few years, tax incentives have led to the excessive construction of office buildings and record vacancy rates; overinvestment in agriculture tax shelters by high-income investors with little knowledge of farming; and distortions at all levels of business—from financing choices to production decisions.

The committee desires to make the tax treatment of diverse economic activity more even. Equitable taxation promotes the efficient allocation of investment and yields productivity gains without requiring additional saving. The committee bill repeals the investment tax credit, which discriminated against long-lived investment and was often used as a tax shelter device. The incentive for investment provided by the credit instead will be provided by lower tax rates and accelerated depreciation.

The committee bill preserves and generally liberalizes for most equipment the present-law Accelerated Cost Recovery System. To offset in part the loss of the investment credit, the rate of depreciation is accelerated for most equipment. The depreciation period of certain assets, such as real property and long-lived equipment, is lengthened to reflect more closely their actual useful life. The committee believes these changes help provide a more efficient capital cost recovery system.

The lower tax rates provided by the committee bill also reduce financing inefficiencies. High marginal tax rates favor debt financing over equity financing, due to the deductibility of interest payments. This creates an incentive for highly leveraged takeovers and leaves firms vulnerable to severe financial stress.

The committee bill also adopts reforms affecting the availability of tax-exempt financing. The committee recognizes the efficiencies of allowing joint public-private partnerships in the provision of government services and has liberalized management contract rules for government facilities. At the same time, the committee bill restricts tax-exempt financing for fundamentally private activities.

The committee bill generally preserves present law for natural resources, and retains a number of business incentives that the committee believes to be beneficial to the economy. The research and development tax credit, which expired at the end of 1985, is extended for four additional years at a 25-percent rate. The benefits to society of research are frequently greater than the compensation received by those undertaking the risks of research. Extending the R&D credit helps ensure that adequate amounts of re-

search are undertaken. Certain expired business energy tax credits also are temporarily extended by the bill, though at reduced rates.

The bill provides a new tax credit for low-income rental housing to consolidate the uncoordinated subsidies under present law. The credit is better targeted to low-income individuals than provisions under present law, and requires that tenants' rents are limited to affordable amounts in relation to their incomes. The committee bill also preserves rehabilitation tax credits for historic and pre-1936 structures at a reduced rate. The credit has been found to be useful in revitalizing depressed urban areas and in preserving America's architectural past for future generations.

In conclusion, the committee believes that this tax reform bill provides a simpler, fairer, and more efficient tax system. The changes made by this bill represent a historic reform of the Federal income tax structure. By guaranteeing individuals and corporations much lower tax rates, the need for special tax preferences is greatly diminished. The bill eliminates needless interference with economic activity and establishes the framework for a growing and productive economy.

III. BUDGET EFFECT OF THE BILL

Tables III-1 and III-2, following, present estimated budget effects of the committee bill for fiscal years 1986-1991. Each of the tables gives amounts by title of the bill and by effect on individual, corporate, excise, employment, and estate and gift tax receipts (and outlays). Table III-2 shows more detailed estimates by provision within each title.

Over the six-year period, 1986-1991, the committee tax reform bill is estimated to be close to neutral, with a negative net budget effect of \$952 million (or by less than 0.1 percent of total estimated tax revenues) over the six-year period.

**Table III-1.—Summary of Estimated Budget Effects of H.R. 3838, as Reported by the Committee on Finance,
Fiscal Years 1986-1991**

[Millions of dollars]

Title of Bill	1986	1987	1988	1989	1990	1991	1986-91
<i>I. Individual Income Tax Provisions</i>							
Individual		-12,242	-64,041	-65,653	-56,627	-58,069	-256,632
Corporate		652	1,109	1,263	1,474	1,628	6,126
Total		11,590	-62,932	-64,390	-55,153	-56,441	-250,506
<i>II. Accelerated Cost Recovery System and Investment Tax Credit</i>							
Individual	856	4,315	3,212	4,268	5,913	8,024	26,588
Corporate	7,398	18,377	17,017	22,464	28,724	36,767	130,747
Total	8,254	22,692	20,229	26,732	34,637	44,797	157,335
<i>III. Accounting Provisions</i>							
Individual		300	806	897	894	822	3,719
Corporate		7,238	11,188	10,918	10,489	10,126	49,959
Total		7,538	11,989	11,815	11,383	10,948	53,673
<i>IV. Capital Gains & Losses</i>							
Individual		(¹)	(¹)	(¹)	(¹)	(¹)	(¹)

V. Compliance and Tax Ad-

<i>Administration</i>						
Individual	3,003	3,645	2,925	3,025	3,389	15,997
Corporate	817	1,989	2,750	3,069	3,335	11,960
Excise	4	4	4	4	4	20
Estate and Gift	4	4	4	4	4	20
<hr/>						
Total	3,828	5,642	5,683	6,112	6,732	27,997

*VI. Corporate and General
Business Taxation*

Individual	-673	1,709	639	980	850	3,505
Corporate	-7,616	-22,204	-30,025	-32,052	-33,355	-125,267
Employment	-561	-223	-35	78	-37	-778
Excise	(4)	68	75	82	90	315
Total	-15	-20,650	-29,346	-30,912	-32,452	-122,225

*VII. Agriculture, Energy, and
Natural Resources*

Individual	10	34	14	13	16	87
Corporate	-216	-71	26	38	27	-348
Employment	-15	-21	-24	-27	-29	-116
Excise	(2)	(2)	(2)	(2)	(2)	(3)
Customs	(4)	(4)	(4)	(4)	(4)	(3)
Total	-152	-58	16	24	14	-377

VIII. Financial Institutions

Individual	-3	-1	-1	-1	-1	-7
Corporate	55	28	.....	16	49	148
Total	52	27	-1	15	48	141

Table III-1.—Summary of Estimated Budget Effects of H.R. 3838, as Reported by the Committee on Finance,
Fiscal Years 1986-1991—Continued

[Millions of dollars]

Title of Bill	1986	1987	1988	1989	1990	1991	1986-91
<i>IX. Foreign Tax Provisions</i>							
Individual.....	24	34	45	56	61	220	
Corporate.....	431	759	841	957	1,068	4,056	
Total	455	793	886	1,013	1,129	4,276	
<i>X. Insurance Products and Companies</i>							
Individual.....	(⁴)	(⁴)	(⁴)	(⁴)	(⁴)	(³)	
Corporate.....	1,059	1,968	2,052	2,144	2,163	9,386	
Total	1,059	1,968	2,052	2,144	2,163	9,386	
<i>XI. Minimum Tax Provisions</i>							
Individual.....	426	2,002	1,645	1,225	1,211	6,539	
Corporate.....	3,877	6,947	7,207	7,318	7,979	33,328	
Total	4,303	8,949	8,852	8,573	9,190	39,867	
<i>XII. Pensions and Deferred Compensation; Employee Benefits; ESOPs</i>							
Individual.....	1,908	6,222	7,620	9,382	10,534	35,666	
Corporate.....	1,101	955	269	117	40	2,482	
Excise	-10	-10	30	30	30	70	
Employment.....	-130	-112	-144	-166	-177	-729	
Total	2,869	7,055	7,775	9,363	10,427	37,489	

XIII. Research and Development

Individual	-32	-91	-104	-118	-92	-23	-460
Corporate.....	-616	-1,733	-1,772	-1,735	-1,238	-654	-7,748
Total	-648	-1,824	-1,876	-1,853	-1,330	-677	-8,208

XIV. Tax Shelters; Interest Expense; Real Estate

Individual	2,108	10,224	13,738	17,356	18,823	62,249
Corporate.....	-605	-2,276	-3,000	-3,552	-3,521	-12,954
Total	1,503	7,948	10,738	13,804	15,302	49,295

XV. Tax-Exempt Bonds

Individual	-23	-127	-317	-475	-557	-1,499
Corporate.....	-2	-13	-29	-47	-65	-156
Total	-25	-143	-353	-533	-637	-1,691

XVI. Taxation of Trusts and Estates; Income of Minor Children; Estate and Gift Taxes

Individual	1,727	841	602	645	694	4,509
Estate and Gift	-105	-26	(³)	(³)	(³)	-131
Total	1,622	815	602	645	694	4,378

XVII. Miscellaneous Tax Provisions

Individual	-9	-48	-29	-19	-28	-201
Corporate.....	-35	-163	-252	-180	-152	-1,085
Total	-44	-211	-281	-199	-180	-1,286

Table III-1.—Summary of Estimated Budget Effects of H.R. 3838, as Reported by the Committee on Finance,
Fiscal Years 1986-1991—Continued

[Millions of dollars]

Title of Bill	1986	1987	1988	1989	1990	1991	1986-91
<i>XVIII. Technical Corrections</i>							
Individual.....		-180	-24	-25	-27	-31	-287
Corporate.....		-206	-99	34	34	28	-209
Total		-386	-123	9	7	-3	-496
Totals:							
Individual.....	815	561	-35,636	-33,750	-17,712	-14,295	-100,007
Corporate.....	5,580	23,066	15,214	12,776	17,300	25,448	100,384
Excise.....		-6	-62	109	116	124	405
Employment.....		-706	-356	-203	-115	-243	-1,623
Estate and Gift.....		-101	-225	4	4	4	111
Customs.....		(⁴)	(⁴)	(⁴)	(⁴)	(⁴)	(³)
Grand Total	7,395	22,814	-20,738	-21,064	-407	11,048	-952

¹ The effects of changes relating to capital gains are included with rate changes in Title I.

² Loss of less than \$5 million.

³ Amounts have not been assigned to footnotes for summation purposes. Therefore, totals do not include estimates represented by footnotes.

⁴ Gain of less than \$5 million.

Table III-2.—Estimated Budget Effects of H.R. 3838, as Reported by the Committee on Finance,
Fiscal Years 1986-1991

[Millions of dollars]

Title and Provision	1986	1987	1988	1989	1990	1991	1986-91
I—Individual Income Tax Provisions							
Rate reductions ¹		-2,511	-52,885	-47,743	-36,715	-35,971	-175,825
Increase in standard deduction		-1,104	-5,869	-7,971	-8,731	-9,565	-33,240
Personal exemption increase		-13,127	-26,170	-27,083	-29,146	-31,332	-126,858
Repeal second earner deduction		1,428	6,108	5,848	6,217	6,609	26,210
Increase the earned income tax credit ²		-53	-1,576	-3,942	-4,490	-5,062	-15,123
Repeal income averaging		436	1,855	2,017	2,170	2,333	8,811
Taxation of unemployment compensation		235	775	723	723	701	3,183
Taxation of prizes and awards		-19	-52	-55	-58	-61	-245
Repeal sales tax deduction		714	4,621	3,867	4,045	4,232	17,479
Increase medical expense deduction floor		350	2,313	2,225	2,305	2,388	9,581
Housing allowances for clergy and military personnel		(³)	(³)	(³)	(³)	(³)	(⁴)
Limitations on deductions for meals, travel, and entertainment							
Individual		556	934	1,054	1,231	1,359	5,134
Corporate		652	1,109	1,263	1,474	1,628	6,126
Miscellaneous itemized deductions; employee business expense		853	5,578	5,040	5,468	5,932	22,871
Repeal political contributions tax credit			327	341	354	368	1,390
Subtotal, Individual Income Tax							
Individual		-12,242	-64,041	-65,653	-56,627	-58,069	-256,632
Corporate		652	1,109	1,263	1,474	1,628	6,126
Total		-11,590	-62,932	-64,390	-55,153	-56,441	-250,506
II—ACRS and ITC							
Depreciation, expensing							
Individual		-153	-404	-273	337	1,557	1,064
Corporate		-879	-2,311	-2,231	-158	4,017	-1,562
Investment tax credit							
Individual		856	3,616	4,541	5,576	6,467	25,524

Table III-2.—Estimated Budget Effects of H.R. 3838, as Reported by the Committee on Finance,
Fiscal Years 1986-1991—Continued

[Millions of dollars]

Title and Provision	1986	1987	1988	1989	1990	1991	1986-91
Corporate.....							
Repeal finance leasing							
Corporate.....	7,398	19,256	19,195	24,340	28,407	32,281	130,877
Subtotal, ACRS and ITC			133	355	475	469	1,432
Individual.....	856	4,315	3,212	4,268	5,913	8,024	26,588
Corporate.....	7,398	18,377	17,017	22,464	28,724	36,767	130,747
Total.....	8,254	22,692	20,229	26,732	34,637	44,797	157,335
III—Accounting Provisions							
Limitation on the use of cash accounting							
Individual.....			-10				-10
Corporate.....		79	166	177	181	189	792
Require utilities to accrue earned but unbilled income							
Corporate.....		191	356	384	387	200	1,518
Recognition of gain on pledges of installment obligations							
Individual.....		19	50	36	36	37	178
Corporate.....		1,272	1,663	1,345	1,358	1,395	7,032
Capitalization of inventory, construction, and development costs							
Individual.....		178	473	576	607	610	2,444
Corporate.....		4,785	7,593	7,690	7,239	7,025	34,332
Repeal of reserve for bad debt for nonfinancial institutions							
Individual.....		31	89	82	83	83	368
Corporate.....		842	1,291	1,232	1,243	1,244	5,852
Qualified discount coupons							
Corporate.....		13	25	28	29	30	125
Discharge of indebtedness							
Individual.....		2	4	3	3	2	14

Corporate.....	57	79	62	52	43	293
Partnership, Sub S, and personal service tax year conformity.....						
Individual.....	70	200	200	165	90	725
Subtotal, Accounting						
Individual.....	300	806	897	894	822	3,719
Corporate.....	7,238	11,178	10,918	10,489	10,126	49,959
Total.....	7,538	11,984	11,815	11,383	10,948	53,673

IV—Capital Gains and Losses

Capital gains						
Individual.....	(1)	(1)	(1)	(1)	(1)	(1)
Incentive stock options						
Individual.....	(3)	(3)	(3)	(3)	(3)	(4)
Tax straddles						
Individual.....	(8)	(8)	(8)	(8)	(8)	(4)
Subtotal, Capital Gains						
Individual.....	(4)	(4)	(4)	(4)	(4)	(4)

V—Compliance and Tax Administration ⁵

Penalty provisions and voluntary disclosure						
Individual.....	447	319	336	341	346	1,789
Corporate.....	61	117	140	138	137	593
Estate and gift.....	4	4	4	4	4	20
Excise.....	4	4	4	4	4	20
Interest provisions ⁷						
Individual.....	95	193	164	163	210	825
Corporate.....	202	311	204	262	344	1,323
Information reporting provisions						
Individual.....	68	317	488	623	648	2,144
Corporate.....	(8)	70	5	5	(8)	80
Tax shelter provisions						
Individual.....	15	88	54	(8)	(8)	157
Revised estimated tax rules						
Individual.....	1,385	75	44	104	80	1,688
IRS Trust Fund ⁶						
Individual.....	993	1,346	1,778	1,627	1,910	7,654
Corporate.....	554	1,491	2,401	2,664	2,854	9,964

**Table III-2.—Estimated Budget Effects of H.R. 3838, as Reported by the Committee on Finance,
Fiscal Years 1986-1991—Continued**

[Millions of dollars]

Title and Provision	1986	1987	1988	1989	1990	1991	1986-91
Employee withholding schedule							
Individual			1,307	61	177	195	1,740
Subtotal, Compliance and Tax Administration							
Individual	3,003		3,645	2,925	3,035	3,389	15,997
Corporate	817		1,989	2,750	3,069	3,335	11,960
Excise	4		4	4	4	4	20
Estate & Gift	4		4	4	4	4	20
Total	3,828		5,642	5,683	6,112	6,732	27,997
VI—Corporate and General Business Taxation							
Corporate rate reductions		-8,092	-22,880	-30,591	-32,564	-33,854	-127,981
Dividends received deduction							
Corporate		139	217	218	236	254	1,064
Dividend exclusion							
Individual		228	604	607	673	748	2,860
NOL provisions							
Corporate		18	45	49	49	49	210
Extraordinary dividends							
Corporate		30	50	53	55	58	246
Basis allocation							
Individual		-2	2	9	13	16	38
Amortization of trademarks and tradenames							
Individual		60	53	56	61	64	294
Corporate		1	4	8	14	20	47
Bus operating authorities							
Corporate		3	9	17	27	37	93
Credit limitations							
Corporate		-5					-20
		231	302	173	84	37	827

Regulated investment companies						
Individual	(8)	1,395	116	128	140	1,779
Excise	(8)	68	75	82	90	315
Federal tax deposit threshold						
Individual	-900	-296	-101	152	-74	-1,219
Employment	-561	-223	-35	78	-37	-778
Subtotal, Corporate and General Business						
Individual	-673	1,709	639	980	850	3,505
Corporate	-7,616	-22,204	-30,025	-32,052	-33,355	-125,267
Employment	-561	-223	-35	78	-37	-778
Excise	(8)	68	75	82	90	315
Total	-8,850	-20,650	-29,346	-30,912	-32,452	-122,225
VII—Agriculture, Energy, and Natural Resources						
Repeal expensing of conservation and field clearing expenditures						
Individual	9	26	24	24	23	106
Corporate	8	12	11	11	11	53
Prepayments						
Individual	11	24	8	9	11	63
Discharge of farm indebtedness						
Individual	-9	-10	-8	-7	-5	-34
Special rule for expenses incurred in replanting						
Individual	-1	-6	-10	-13	-13	-43
Energy credits and related incentives						
Individual	(8)	(8)	(8)	(8)	(8)	(4)
Corporate	-228	-89	10	22	15	-422
Excise	(3)	(3)	(3)	(3)	(3)	(4)
Customs	(8)	(8)	(8)	(8)	(8)	(4)
Foreign IDCs and mining exploration costs						
Corporate	4	6	5	5	1	21
Conservation easement donations						
Individual	(3)	(3)	(3)	(3)	(3)	(4)
FUTA provisions for agricultural wages						
Employment	-15	-21	-24	-27	-29	-116
Subtotal, Energy, Agriculture, Timber, and Natural Resources						
Individual	10	34	14	13	16	87

Table III-2.—Estimated Budget Effects of H.R. 3838, as Reported by the Committee on Finance,
Fiscal Years 1986-1991—Continued

[Millions of dollars]

Title and Provision	1986	1987	1988	1989	1990	1991	1986-91
VIII—Financial Institutions							
Limitation on bad debt reserves							
Corporate.....	-152	-216	-71	26	38	27	-348
Employment.....		-15	-21	-24	-27	-29	-116
Excise.....	(³)	(³)	(³)	(³)	(³)	(⁴)	(⁴)
Customs.....		(⁸)	(⁸)	(⁸)	(⁸)	(⁸)	(⁴)
Total.....	-152	-221	-58	16	24	14	-377
Special carryover NOL carryover rules for depository institutions							
Corporate.....		55	90	98	113	130	486
Treatment of losses on deposits in insolvent financial institutions							
Corporate.....			-62	-98	-97	-81	-338
Individual.....		-3	-1	-1	-1	-1	-7
Subtotal, Financial Institutions							
Individual.....		-3	-1	-1	-1	-1	-7
Corporate.....		55	28	(⁸)	16	49	148
Total.....		52	27	-1	15	48	141
IX—Foreign Tax Provisions							
Separate limitation for passive income							
Corporate.....		259	422	410	437	467	1,995
Separate limitation for high taxed interest income							
Corporate.....		85	152	149	149	148	683
Deemed-paid credit							
Corporate.....		6	20	60	86	97	269
Limitation on special treatment of 80-20 corporations							
Corporate.....		(⁸)	(⁸)	(⁸)	(⁸)	(⁸)	(⁴)

**Table III-2.—Estimated Budget Effects of H.R. 3838, as Reported by the Committee on Finance,
Fiscal Years 1986-1991—Continued**

[Millions of dollars]

Title and Provision	1986	1987	1988	1989	1990	1991	1986-91
Life insurance company provisions							
Corporate.....		391	678	729	783	839	3,420
Property and casualty insurance provisions							
Corporate.....		668	1,290	1,323	1,361	1,324	5,966
Subtotal, Insurance Products and Companies							
Individual.....	(⁽⁸⁾)	(⁽⁸⁾)	(⁽⁸⁾)	(⁽⁸⁾)	(⁽⁸⁾)	(⁽⁸⁾)	(⁽⁴⁾)
Corporate.....	1,059	1,059	1,968	2,052	2,144	2,163	9,386
Total.....	1,059	1,059	1,968	2,052	2,144	2,163	9,386
XI—Minimum Tax Provisions							
Revise the alternative minimum tax							
Individual.....	426	426	2,002	1,645	1,255	1,211	6,539
Revise corporate minimum tax							
Corporate.....	3,877	3,877	6,947	7,207	7,318	7,979	33,328

**Table III-2.—Estimated Budget Effects of H.R. 3838, as Reported by the Committee on Finance, Fiscal Years
1986-1991—Continued**

[Millions of dollars]

Title and Provision	1986	1987	1988	1989	1990	1991	1986-91
Subtotal, Minimum Tax							
Individual		426	2,002	1,645	1,255	1,211	6,539
Corporate.....		3,877	6,947	7,207	7,318	7,979	33,328
Total.....		4,303	8,949	8,852	8,573	9,190	39,867
XII—Pension and Deferred Compensation; Employee Benefits; ESOPS							
Individual retirement arrangements (IRAs)							
Individual		1,697	5,186	5,715	6,207	6,704	25,509
Qualified cash or deferred arrangements (401(k))							
Individual		190	344	304	300	317	1,455
Repeal exclusion of current annuity income of corporations							
Corporate		3	13	31	48	65	160
Simplified employee plans (SEPs)							
Individual		-15	-29	-28	-33	-37	-142
Minimum standards for qualified plans							
Individual		(8)	(8)	(8)	(8)	(8)	(4)
Uniform distribution requirements							
Individual		(8)	(8)	(8)	(8)	(8)	(4)
Excise							
Tax on pre-retirement distributions							
Individual		47	158	295	411	550	1,461
Replace 10-year averaging with limited 5-year averaging							
Individual		92	48	18	27	38	223
Repeal 3-year basis recovery rule for contributory plans							
Individual			48	829	1,925	2,316	5,118

Loan provisions					
Individual	(s)	(s)	(s)	(s)	(4)
Increase early retirement age with true actuarial reduction	315	869	960	1,097	1,259
Individual					4,500
Adjustments to Sec. 404 limitations	17	42	45	49	54
Individual					207
Tax on qualified plan reversions	-10	-10	30	30	30
Excise					70
Extension of the exclusion for group legal plans	-116	-116	-153	-179	-186
Individual					-750
Employment	-51	-60	-84	-100	-103
Extension of the exclusion for education assistance	-130	-91	-102	-115	-126
Individual					-564
Employment	-79	-52	-60	-66	-74
Self-employed health insurance	-255	-348	-373	-424	-481
Individual					-1,881
Discrimination rules for employee benefits	66	116	128	140	154
Individual					604
Limitation on accrual of vacation pay	5	8	2	2	2
Individual	85	63	17	18	15
Corporate					198
Faculty housing	(s)	(s)	(s)	(s)	(s)
Individual					(4)
Health benefits for retirees	-5	-13	-20	-25	-30
Individual					-93
Changes related to ESOPs	1,013	879	221	51	-40
Corporate					2,124
Subtotal, Pensions and Employee Benefits					
Individual	1,908	6,222	7,620	9,382	10,534
Corporate	1,101	955	269	117	40
					35,666
					2,482

Table III-2.—Estimated Budget Effects of H.R. 3838, as Reported by the Committee on Finance, Fiscal Years 1986-1991—Continued

[Millions of dollars]

Title and Provision	1986	1987	1988	1989	1990	1991	1986-91
Employment		-130	-112	-144	-166	-177	-729
Excise		-10	-10	30	30	30	70
Total		2,869	7,055	7,775	9,363	10,427	37,489
XIII—Research and Development							
Incremental Research Tax Credit							
Individual.....	-32	-91	-104	-118	-92	-23	-460
Corporate.....	-616	-1,234	-1,522	-1,721	-1,223	-637	-6,953
Application of research expenses to foreign source income (Sec. 861)							
Corporate.....		-452	-237	.....	.....	.....	-689
Personal holding companies							
Corporate.....		-47	-13	-14	-15	-17	-106
Subtotal, Research and Development							
Individual.....	-32	-91	-104	-118	-92	-23	-460
Corporate.....	-616	-1,733	-1,772	-1,735	-1,238	-654	-7,748
Total	-648	-1,824	-1,876	1,853	-1,330	-677	-8,208
XIV—Tax Shelters; Interest Expense; and Real Estate							
Limitation on passive losses							
Individual.....		1,410	5,139	6,818	8,597	9,430	31,394
Corporate.....		-587	-2,194	-2,996	-3,570	-3,402	-12,749
Limitation on deduction for nonbusiness interest							
Individual.....		723	5,059	6,616	7,780	8,014	28,192
At-risk rules							
individual.....		31	125	214	302	470	1,142
Corporate.....		-44	-129	-196	-288	-450	-1,107
Rehabilitation tax credits							
Individual.....		16	115	415	1,117	1,460	3,123

Corporate.....	28	52	197	312	337	926
low-income housing credit						
Individual.....	-60	-201	-312	-426	-536	-1,535
real estate investment trusts						
Individual.....	-12	-13	-13	-14	-15	-67
mortgage-backed securities						
Corporate.....	-2	-5	-5	-6	-6	-24
Subtotal, Real Estate						
Individual.....	2,108	10,224	13,738	17,356	18,823	62,249
Corporate.....	-605	-2,276	-3,000	-3,552	-3,521	-12,954
Total.....	1,503	7,948	10,738	13,804	15,302	49,295

XV—Tax-Exempt Bonds						
Individual.....	-23	-127	-317	-475	-557	-1,499
Corporate.....	-2	-13	-29	-47	-65	-156
Total.....	-25	-143	-353	-538	-637	-1,691

XVI—Unearned Income of Minor Children; Trusts and Estates; Estate and Gift Taxes

Income of a minor child						
Individual.....	64	198	217	239	263	981
Revise taxation of estates and trusts						
Individual.....	57	209	226	244	265	1,011
Tax deferral for trusts						
Individual.....	1,169	123	128	130	132	1,682
Payment of income tax on estates and trusts						
Individual.....	427	311	31	32	34	835
Estate tax current use valuation						
Estate and gift.....	(3)	(3)	(3)	(3)	(3)	(4)

Table III-2.—Estimated Budget Effects of H.R. 3838, as Reported by the Committee on Finance, Fiscal Years 1986-1991—Continued

[Millions of dollars]

Title and Provision	1986	1987	1988	1989	1990	1991	1986-91
Disclaimers for gift and estate taxes							
Estate Gift ^a		-105	-26	(³)	(³)	(³)	-131
Subtotal, Trusts and Estates							
Individual		1,727	841	602	645	694	4,509
Estate and gift		-105	-26	(⁴)	(⁴)	(⁴)	-131
Total		1,622	815	602	645	694	4,378
XVII—Miscellaneous Tax Provisions							
Extend targeted jobs tax credit							
Individual	-9	-46	-62	-18	(³)	(³)	-135
Corporate	-22	-134	-265	-202	-112	-65	-800
Extension of expensing for removal of architectural barriers							
Corporate	-9	-17	-18	-19	-20	-21	-104
Rules for spouses of MIA's							
Individual		(³)	(³)	(³)	(³)	(³)	(⁴)
Exchanges and rentals of certain membership lists							
Corporate	-4	-7	-8	-9	-11	-12	-51
Tax exemption for certain title holding companies							
Individual		-2	-6	-11	-19	-28	-66
Corporate		-5	-12	-22	-37	-54	-130
Foundation business holdings							
Corporate		(³)	(³)	(³)	(³)	(³)	(⁴)
Interest and tax deductions of cooperative housing corporations							
Individual		(³)	(³)	(³)	(³)	(³)	(⁴)
Subtotal, Miscellaneous Tax Provisions							
Individual	-9	-48	-68	-29	-19	-28	-201
Corporate	-35	-163	-303	-252	-180	-152	-1,085

Total.....	-44	-211	-371	-281	-199	-180	-1,286
XVIII—Technical Corrections							
Individual		-180	-24	-25	-27	-31	-287
Corporate		-206	-99	34	34	28	-209
Total.....		-386	-123	9	7	-3	-496
Total, Tax Reform							
Individual	815	561	-35,636	-33,750	-17,712	-14,285	-100,007
Corporate	6,580	23,066	15,214	12,776	17,300	25,448	100,384
Excise		-6	62	109	116	124	405
Employment		-706	-356	-203	-115	-243	-1,623
Estate and gift		-101	-225	4	4	4	-111
Customs		(^a)	(^a)	(^a)	(^a)	(^a)	(^a)
GRAND TOTAL	7,395	22,814	-20,738	-21,064	-407	11,048	-952

¹ Rate change lines include the effects of changes relating to capital gains as well as interactions between rate changes and other provisions of the bill.

² Includes increased outlays. Changes to the earned income credit will increase outlays by \$50 million in 1987, \$1,376 million in 1988, \$3,155 million in 1989, \$3,505 million in 1990, and \$3,846 million in 1991.

³ Loss of less than \$5 million.

⁴ Amounts have not been assigned to footnotes for summation purposes. Therefore, totals do not include estimates represented by footnotes.

⁵ Section dealing with attorney's fees will increase outlays by less than \$5 million annually.

⁶ Includes increased outlays. The IRS Trust Fund provision will increase outlays by \$465 million in 1987, \$765 million in 1988, \$1,030 million in 1989, \$1,055 million in 1990, and \$1,100 million in 1991.

⁷ Includes negligible outlay effects.

⁸ Gain of less than \$5 million.

⁹ Amounts represent refunds of tax previously collected.

Revenue Effect

The provision is estimated to increase fiscal year budget receipts by \$235 million in 1987, \$775 million in 1988, \$749 million in 1989, \$723 million in 1990, and \$701 million in 1991.

2. Tax treatment of prizes and awards (sec. 122 of the bill and secs. 74, 102, and 274 of the Code)

Present Law

Under section 74, prizes and awards received by an individual (other than scholarships or fellowship grants) generally are includible in gross income. Treasury regulations provide that taxable prizes and awards include amounts received from giveaway shows, door prizes, awards in contests of all types, and awards from an employer to an employee in recognition of some achievement in connection with employment.

Section 74(b) provides a special exclusion from income for certain prizes and awards that are received for achievements in fields such as charity, the sciences, and the arts. This exclusion does not apply unless the recipient (1) has not specifically applied for the prize or award (for example, by entering a contest), and (2) is not required to render substantial services as a condition of receiving it. Treasury regulations state that the section 74(b) exclusion does not apply to prizes or awards from an employer to an employee in recognition of some achievement in connection with employment.¹

While section 74 determines the includibility in income of prizes and awards, the treatment of other items provided by an employer to an employee may be affected by section 61, defining gross income, and section 102, under which gifts may be excluded from gross income. Section 61 provides in part that "gross income means all income from whatever source derived," including compensation for services whether in the form of cash, fringe benefits, or similar items. However, an item transferred from an employer to an employee, other than a prize or award that is includible under section 74, may be excludable from gross income if it qualifies as a gift under section 102.

The U.S. Supreme Court, in a case involving payments made "in a context with business overtones," has defined excludable gifts as payments made out of "detached and disinterested generosity" and not in return for past or future services or from motives of anticipated benefit (*Comm'r v. Duberstein*, 363 U.S. 278 (1960)). Under this standard, the Court said, transfers made in connection with employment constitute gifts only in the "extraordinary" instance.²

¹ Treas. Reg. sec. 1.74-1(b). But see *Jones v. Comm'r*, 743 F.2d 1429 (9th Cir. 1984), holding that an award from an employer to an employee can qualify for the present-law section 74(b) exclusion under extraordinary circumstances. The court held that the exclusion applied in the case of a prominent scientist who was rewarded by the National Aeronautics and Space Administration (NASA) for lifetime scientific achievement, only part of which was accomplished while the scientist was employed by NASA. No inference is intended as to whether the decision of this case is correct under present law.

² Under *Duberstein*, the determination of whether property transferred from an employer to an employee (or otherwise transferred in a business context) constitutes a gift to the recipient is to be made on a case-by-case basis, by an "objective inquiry" into the facts and circumstances. If the transferor's motive was "the incentive of anticipated benefit," or if the payment was in return for services rendered (whether or not the payor received an economic benefit from the payment), then the payment must be included in income by the recipient.

Under certain circumstances, if an award to an employee constitutes an excludable gift, the employer's deduction may be limited pursuant to section 274(b). That section expressly defines the term "gift" to mean any amount excludable from gross income under section 102 that is not excludable under another statutory provision.

Section 274(b) generally disallows business deductions for gifts to the extent that the total cost of all gifts of cash, tangible personal property, and other items to the same individual from the taxpayer during the taxable year exceeds \$25. Under an exception to the \$25 limitation, the ceiling on the deduction is \$400 in the case of an excludable gift of an item of tangible personal property awarded to an employee for length of service, safety achievement, or productivity. In addition, the ceiling on the employer's business gift deduction is \$1,600 for an excludable employee award for such purposes when provided under a qualified award plan, if the average cost of all plan awards in the year does not exceed \$400.

A further rule that may be relevant with respect to a prize or award arises under section 132(e), which provides that de minimis fringe benefits are excludable from income. A de minimis fringe generally is defined as "any property or service the value of which is (taking into account the frequency with which similar fringes are provided by the employer to the employer's employees) so small as to make accounting for it unreasonable or administratively impracticable."

Reasons for Change

Present-law exclusion

Prizes and awards generally increase an individual's net wealth in the same manner as any other receipt of an equivalent amount that adds to the individual's economic well-being. For example, the receipt of an award of \$10,000 for scientific or artistic achievement which present law treats as tax-exempt increases the recipient's net wealth and ability to pay taxes to the same extent as the receipt of \$10,000 in wages, dividends, or as a taxable award. Accordingly, the committee believes that prizes and awards generally should be includible in income even if received due to achievement in fields such as the arts and sciences.

In addition, the committee is concerned about problems of complexity that have arisen as a result of the present-law exclusion under section 74(b). The questions of what constitutes a qualifying form of achievement, whether an individual took action to enter a contest or proceeding, and whether or not the conditions of receiving a prize or award involve rendering "substantial" services, have all caused some difficulty in this regard. Finally, in some circumstances the present-law exclusion may serve as a possible vehicle for the payment of disguised compensation.

At the same time, the committee recognizes that in some instances the recipient of the type of prize or award described in section 74(b) may wish to assign it to charity, rather than claiming it for personal use. Accordingly, the bill provides that a prize or award meeting the present-law exclusion requirements under section 74(b) is excludable from gross income if, and only if, the prize

or award is transferred by the payor, pursuant to a designation made by the winner of the prize or award, to a governmental unit or to a tax-exempt charitable, educational, religious, etc. organization contributions to which are deductible under section 170(c)(1) or section 170(c)(2), respectively.

Employee awards

An additional reason for change relates to the tax treatment of employee awards of tangible personal property given by reason of length of service, safety achievement, or productivity. Except for items that may be able to qualify as de minimis fringes as defined by section 132(e), such employee awards are not excludable from the employee's gross income, and the deduction of their cost by the employer is not limited under section 274(b), if they cannot qualify as gifts because of either the "detached generosity" standard applicable under section 102 or the rule of section 74(a) that prizes and awards generally are includible in income.

The committee understands that uncertainty has arisen among some taxpayers concerning the proper tax treatment of an employee award. This uncertainty could lead some employers to seek to replace amounts of taxable compensation (such as sales bonuses) with "award" programs of tangible personal property. The business and the employee might contend that such awards are free from income or social security tax, but that the employer could still deduct the costs of the awards up to the section 274(b) limitations. In the case of highly compensated employees, who often might not be significantly inconvenienced by the fact that such awards would be made in the form of property rather than cash, an exclusion for transfers of property with respect to regular job performance (such as for productivity) could serve as a means of providing tax-free compensation.

Accordingly, the committee believes that it is desirable to provide express rules in this area. The committee believes that, in general, an award to an employee from his or her employer does not constitute a "gift" comparable to such excludable items as intrafamily holiday gifts, and should be included in the employee's gross income for income tax purposes and in wages for withholding and employment tax purposes. However, the committee believes that no serious potential for avoiding taxation on compensation arises from transfers by employers to employees of items of minimal value. Therefore, the committee wishes to clarify that the section 132(e) exclusion under present law for de minimis fringe benefits can apply to employee awards of low value, including traditional awards (such as a gold watch) upon retirement after lengthy service for an employer. In that case, the award is not made in recognition of any particular achievement, relates to many years of employment, and does not reflect any expectation of or incentive for the recipient's rendering of future services.

Also, the committee believes that, in certain narrowly defined circumstances, it is appropriate to recognize traditional business practices of making awards of tangible personal property for length of service or safety achievement. These traditional practices involve awards of such items as engraved plaques, desk accessories, or emblematic jewelry that identify or symbolize the awarding em-

ployer or the achievement being recognized, and awards of items such as watches on retirement after lengthy service; such specialized items are not strictly equivalent, for example, to providing either a bonus in cash or an allowance of a dollar amount toward the purchase of ordinary merchandise. The committee believes that the double income tax benefit of excludability and deductibility is acceptable for such employee achievement awards under rules intended to prevent abuse and limit the scope of the double benefit.

Thus, the bill restricts the double benefit through dollar limitations, limits the frequency with which length of service awards can be made to the same employee, and limits safety achievement awards to the employer's nonprofessional work force and to no more than 10 percent of such eligible recipients in one year. In addition, the exclusion applies only if the item of tangible personal property is awarded under conditions and circumstances that do not create a significant likelihood of the payment of disguised compensation. Moreover, the committee believes that the fair market value of any prize or award to an employee that does not constitute either a length of service award or a safety achievement award qualifying under the bill or a de minimis fringe under section 132 should be includible in gross income for income tax purposes and (like employee achievement awards excludable for income tax purposes under the bill) in wages for employment tax purposes.

Explanation of Provisions

Scientific, etc. awards

Under the bill, the present-law exclusion under section 74(b) for certain prizes and awards for charitable, artistic, scientific, and like achievements is modified to apply only if the recipient designates that the prize or award is to be transferred by the payor to a governmental unit or a tax-exempt charitable, educational, religious, etc. organization contributions to which are deductible under section 170(c)(1) or 170(c)(2), respectively. If such designation is made and the prize or award is so transferred to a governmental unit or charitable organization by the payor, the prize or award is not included in the winner's gross income, and no charitable deduction is allowed either to the winner or to the payor on account of the transfer to the governmental unit or charitable organization.

For purposes of determining whether a prize or award that is so transferred qualifies as excludable under the bill, the present-law rules concerning the scope of section 74(b) are retained without change. In addition, in order to qualify for the section 74(b) exclusion as modified by the bill, the designation must be made by the taxpayer, and must be carried out by the organization making the prize or award, before the taxpayer uses the item that is awarded (e.g., in the case of an award of money, before the taxpayer spends, deposits, invests, or otherwise uses the money). Disqualifying uses by the taxpayer include such uses of the property with the permission of the taxpayer or by one associated with the taxpayer (e.g., a member of the taxpayer's family).

Employee awards

In general

The bill provides an exclusion from gross income, subject to certain dollar limitations, for an "employee achievement award" that satisfies the requirements set forth in the bill. The bill defines an employee achievement award as an item of tangible personal property transferred by an employer to an employee for length of service achievement or for safety achievement, but only if the item (1) is awarded as part of a meaningful presentation, and (2) is awarded under conditions and circumstances that do not create a significant likelihood of the payment of disguised compensation.³ The exclusion applies only for awards of tangible personal property and is not available for awards of cash, gift certificates, or equivalent items.

An award for length of service cannot qualify for the exclusion if it is received during the employee's first five years of employment for the employer making the award, or if the employee has received a length of service achievement award (other than an award excludable under section 132(e)) from the employer during the year or any of the preceding four years. An award for safety achievement cannot qualify for the exclusion if made to an employee other than an eligible employee, or if, during the year, employee awards for safety achievement have previously been awarded by the employer to more than 10 percent of the employer's eligible employees. For this purpose, eligible employees are all employees of the taxpayer other than managers, administrators, clerical workers, and other professional employees, because persons occupying these positions do not engage in work involving significant safety concerns.

Deduction limitations

Under section 274 as amended by the bill, the employer's deduction limitation for all employee achievement awards (safety and length of service) provided to the same employee during the taxable year generally is \$400. In the case of one or more qualified plan awards awarded to the same employee during the taxable year, however, the employer's deduction limitation for all such qualified plan awards (safety and length of service) is \$1,600. In addition to these separate \$400/\$1,600 limitations, the \$1,600 limitation applies in the aggregate if an employee receives one or more qualified plan awards during the year, and also one or more employee achievement awards that are not qualified plan awards; i.e., the \$400 and \$1,600 limitations cannot be added together to allow deductions exceeding \$1,600 in the aggregate for employee achievement awards made to the same employee in a taxable year.⁴

³ The types of conditions and circumstances that are to be deemed to create a significant likelihood of payment of disguised compensation include, for example, the making of employee awards at the time of annual salary adjustments or as a substitute for a prior program of awarding cash bonuses, or the providing of employee awards in a way that discriminates in favor of highly paid employees.

⁴ In the case of an employee award provided by a partnership, the deduction limitations of section 274(b) apply to the partnership as well as to each partner.

A qualified plan award is defined as an employee achievement award provided under a qualified award plan, i.e., an established, written plan or program of the taxpayer that does not discriminate in favor of highly compensated employees (within the meaning of sec. 414(q)) as to eligibility or benefits. However, an item cannot be treated as a qualified plan award if the average cost per recipient of all employee achievement awards made under all qualified award plans of the employer during the taxable year exceeds \$400. In making this calculation of average cost, qualified plan awards of nominal value are not to be included in the calculation (i.e., are not to be added into the total of award costs under the plan). In the case of a qualified plan award the cost of which exceeds \$1,600, the entire cost of the item is to be added into the total of award costs under the plan, notwithstanding that only \$1,600 (or less) of such cost is deductible.

Excludable amount

In the case of an employee achievement award the cost of which is fully deductible by the employer under the dollar limitations of section 274 (as amended by the bill),⁵ the fair market value of the award is fully excludable from gross income by the employee. For example, assume that an employer makes a length of service achievement award (other than a qualified plan award) to an employee in the form of a crystal bowl, that the employer makes no other length of service awards or safety achievement awards to that employee in the same year, and that the employee has not received a length of service award from the employer during the prior four years. Assume further that the cost of the bowl to the employer is \$375, and that the fair market value of the bowl is \$415. The full fair market value of \$415 is excludable from the employee's gross income for income tax purposes under section 74 as amended by the bill.

If any part of the cost of an employee achievement award exceeds the amount allowable as a deduction by an employer because of the dollar limitations of section 274, however, then the exclusion does not apply to the entire fair market value of the award. In such a case, the employee must include in gross income the greater of (i) an amount equal to the portion of the cost to the employer of the award that is not allowable as a deduction to the employer (but not an amount in excess of the fair market value of the award) and (ii) the amount by which the fair market value of the award exceeds the maximum dollar amount allowable as a deduction to the employer. The remaining portion of the fair market value of the award is not included in the employee's gross income for income tax purposes.

Consider, for example, the case of a safety achievement award to an eligible employee that is not a qualified plan award, and that costs the employer \$500; assume that no other employee achievement awards were made to the same employee during the taxable year, and that safety achievement awards had not previously been awarded during the year to more than 10 percent of eligible em-

⁵ In the case of a tax-exempt employer, the deduction limitation amount is that amount that would be deductible if the employer were not exempt from taxation.

ployees of the employer. The employer's deduction is limited to \$400. The amount includible in gross income by the employee is the greater of (1) \$100 (the difference between the item's cost and the deduction limitation), and (2) the amount by which the item's fair market value exceeds the deduction limitation. If the fair market value equals, for example, \$475, \$100 is includible in the employee's income. If the fair market value equals \$600, then \$200 is includible in the employee's income.

Except to the extent that the new section 74(c) exclusion or section 132(e) applies, the fair market value of an employee award (whether or not satisfying the definition of an employee achievement award) is includible in the employee's gross income under section 61, and is not excludable under section 74 (as amended by the bill) or section 102 (gifts). The fair market value of an employee award (or any portion thereof) that is not excludable from income must be included by the employer on the employee's Form W-2, as is required under present law.

Any amount of an employee achievement award that is excludable from gross income under the bill is includible in wages or compensation for employment tax (e.g., FICA tax) purposes.

The committee bill does not modify section 132(e), under which de minimis fringe benefits are excluded from gross income. Thus, an employee award is not includible in income if its fair market value, after taking into account the frequency with which similar benefits are provided by the employer to the employer's employees, is so small as to make accounting for it unreasonable or administratively impracticable.

For purposes of sections 74 and 274 (as modified by the bill), an employee award that is excludable under section 132(e) is disregarded in applying the rules regarding how frequently an individual may receive a length of service award, or how many employees of an employer may receive a safety achievement award in the same taxable year. Under appropriate circumstances, however, the fact that an employer makes a practice of giving to its employees length of service or safety achievement awards that qualify under section 74 and 274 may affect the question of whether other items given to such employees (particularly if given by reason of length of service or safety achievement) qualify as de minimis fringe benefits under section 132(e).

The question of whether it is unreasonable or administratively impracticable (within the meaning of sec. 132(e)) to account for an item may be affected by the existence of a program whereby the taxpayer regularly accounts for other like items and complies with the statutory reporting requirements. Moreover, in some cases the fact that a particular employee receives items having the maximum fair market value consistent, respectively, with the employee achievement award and the de minimis fringe benefit exclusions may suggest that the employer's practice is not de minimis. This is particularly so when employee awards and other items, purportedly within the scope of section 132(e), are provided to the same individual in the same year.

The committee expects that the exclusion under section 132(e) for a de minimis fringe benefit will apply, under appropriate circumstances, to traditional retirement gifts presented to an employee on

his or her retirement after completing lengthy service, where the section 74(c) exclusion for length of service awards does not apply because the employee received such an award within the prior four years. In considering whether an item presented upon retirement qualifies as de minimis, the duration of the employee's tenure with the employer generally has relevance. For example, in the case of an employee who has worked for an employer for 25 years, a retirement gift of a gold watch may qualify for exclusion as a de minimis fringe benefit even though gold watches given throughout the period of employment would not so qualify for exclusion.

Effective Date

The provisions relating to the tax treatment of prizes and awards are effective for awards made in taxable years beginning after December 31, 1986.

Revenue Effect

The provisions relating to the tax treatment of prizes and awards are estimated to decrease fiscal year budget receipts by \$19 million in 1987, \$52 million in 1988, \$55 million in 1989, \$58 million in 1990, and \$61 million in 1991.

**TECHNICAL CORRECTIONS IN OTHER PROGRAMS AFFECTED BY THE
DEFICIT REDUCTION ACT OF 1984**

A. Technical Corrections to Social Security Program

1. Special Social Security Treatment for Church Employees (sec. 1882 of the bill, sec. 2603 of the Act, secs. 1402 and 3121 of the Code and sec. 211 of the Social Security Act)

a. Application to members of certain religious faiths

Present Law

The Act allows a church or qualifying church-controlled organization to make a one-time election to exclude from the definition of employment, for purposes of FICA taxes, services performed in the employ of the church or organization. If an election is made to exclude services for FICA purposes, the employee is treated similarly to a self-employed person with respect to those services. Thus, the employee is liable for self-employment ("SECA") taxes on remuneration for such services. The amount of remuneration on which an employee of an electing organization is liable for SECA tax is generally the same as the amount which would have been subject to FICA tax in the absence of an election.

Under section 1402(g) of the Code, an exemption from SECA taxes is provided for self-employed members of a religious sect (e.g., the Amish) who are adherents of established tenets or teachings of that sect, by reason of which such individuals are conscientiously opposed to public or private death, retirement, or medical insurance (including social security). This exemption is not available to employees. This exemption is granted only upon application by the individual, which must include evidence of the sect's tenets or teachings and of the individual's adherence to them. To obtain an exemption, the individual must waive all social security benefits.

Explanation of Provision

The bill makes clear that the exception from SECA taxes for members of certain religious faiths (sec. 1402(g)) is not available for services with respect to which SECA tax is due as a result of an election under the Act. Thus, if a member of a religious faith covered by the sec. 1402(g) exception is an employee of a church or church-controlled organization, and that church or organization elects to treat the employee as self-employed for FICA tax purposes, the employee cannot also claim a section 1402(g) exception from SECA taxes with respect to those services. This provision prevents the combination of an election under the Act, and a section 1402(g) exception, from resulting in an avoidance of any employment taxes on the services performed for the electing organization. This is consistent with the general principle that the tax for serv-

ices covered by an election should be determined (to the extent possible) as it would be under FICA, for which the section 1402(g) exception would be unavailable. The provision does not affect the individual's ability to claim a section 1402(g) exception with respect to other services not covered by an election under the Act.

b. Computation of income subject to SECA tax

Present Law

Under the Act, the remuneration on which the employee of an electing church or organization is liable for SECA tax generally is the same as the amount which would have been subject to FICA tax if that individual had continued to be treated as an employee. Thus, trade or business expenses are not subtracted in computing self-employment income (reimbursed business expenses are not included in self-employment income, however), and the \$400 threshold generally applicable to self-employment income does not apply. Similarly, a \$100 threshold (per employer) for a taxable year applies in determining whether remuneration for services covered by an election is subject to SECA tax. However, after 1989 these employees will be eligible for a deduction, in computing SECA taxes, for the product of net earnings from self-employment and one-half of the SECA rate.

Explanation of Provision

The bill provides several changes to insure that church employee income will be determined, as far as possible, using FICA principles, and that the taxation of other self-employment income will not be affected by an election. Specifically, the bill specifies that the SECA tax base for services covered by an election is to be computed in a separate "basket" from the tax base for other self-employment income. Thus, church employee income is not reduced by any deduction, while other income and deductions are not affected by items attributable to church employee income.¹⁵ (This rule does not apply to the deduction for the product of all net self-employment earnings and one-half the SECA tax rate, beginning after 1989). Additionally, the \$100 threshold for taxing church employee income, and the \$400 threshold applicable to other self-employment income, are separately applied under the bill (i.e., church employee income does not count toward the general \$400 threshold).

This provision is effective only for remuneration paid or derived in taxable years beginning on or after January 1, 1986.

c. Voluntary revocation of election

Present Law

Under the Act, a church or organization must make an election to treat services performed for the church or organization as subject to SECA (rather than FICA) taxes before its first quarterly employment tax return is due, or if later, 90 days after July 18, 1984.

¹⁵ The "optional" method of computing self-employment income applies only to non-church employee income.

Once made, that election may not be revoked by the church or organization. However, an election is to be permanently revoked by the Treasury Department if the electing church or organization fails to provide required information regarding its employees for a period of two years or more and, upon request by the Treasury Department, fails to furnish previously unfurnished information for the period covered by the election. (This information is required in order to monitor compliance with the provisions of the Act.) This rule could allow an electing church or organization effectively to revoke its election by failing to provide the required information.

Explanation of Provision

The bill allows a church or organization to revoke an election under regulations to be prescribed by the Treasury Department. The bill does not amend the present-law rules allowing the Treasury Department to revoke an election for failure to provide required information. A church or organization which revokes an election (or for which the election is revoked) cannot make another election, because the time for making such an election has lapsed.

2. Miscellaneous Corrections (sec. 1883 of the bill)

The bill makes certain corrections in spelling, language, and indentation provisions related to Social Security Act programs.

B. Technical Corrections to AFDC and Child Support Programs

1. Disregard of Income of a Stepparent (sec. 1883(b)(1)(A) of the bill)

Present Law

The AFDC plan requirement pertaining to the treatment of earned income of a stepparent allows a monthly disregard of \$75 (in recognition of work expenses). Current law allows the Secretary to prescribe the disregard or a lesser amount for individuals not in full-time employment or not employed throughout the month.

Explanation of Provision

The bill deletes the Secretary's authority for the disregard of a lesser amount in the case of earnings of a stepfather, since the Deficit Reduction Act deleted the comparable authority for the general income disregard provision of section 402(a)(8) of the Act.

This provision is effective October 1, 1984, the effective date of the Deficit Reduction Act amendment to section 402(a)(8).

2. Family Unit Rule (sec. 1883(b)(2)(A) of the bill)

Present Law

Section 402(a)(38) of the Social Security Act requires the inclusion in the AFDC family unit of all parents of the dependent child, and all siblings who are themselves dependent children.

Explanation of Provision

The bill clarifies that a sibling is to be included in the AFDC family unit who is deprived of parental support or care by reason of the unemployment of a parent (and meets the other criteria of a dependent child) as well as one who is deprived by reason of the death, absence, or incapacity of a parent. No such distinction between these two categories was intended, and this provision will clarify that, in a State that provides AFDC on the basis of the unemployment of a parent, siblings who are dependent children for that reason must be included in the AFDC unit.

This provision is effective October 1, 1984, the date that paragraph (38) was added to section 402(a) of the Act.

3. Income of AFDC Family Unit (sec. 1883(b)(2)(B) of the bill)

Present Law

Section 402(a)(38) of the Social Security Act requires that, in determining the eligibility and benefit amount of the AFDC family unit, all income of family members must be included. Specific reference is made to OASDI benefits paid under title II of the Act.

Explanation of Provision

The bill makes clear that title II benefits, along with income from all other sources, are to be included by the State agency in determining AFDC eligibility and benefits. The provision also clarifies that counting these benefits in this way will not be considered to violate section 208(e). That section makes it a crime, under the general title II rules, for a payee to use the OASDI payments for someone other than the beneficiary. Therefore, this provision clarifies that that latter section is inapplicable to the inclusion of such benefits in the AFDC family's income.

The bill also makes clear that support payments, regardless of the terms of the payer's obligation under State law, must be included as part of the total income available to the family. (This is the same result that occurs when AFDC is paid to the family for a month and the child support agency subsequently collects support on behalf of one or more family members and then reimburses the AFDC agency for assistance already provided.)

This provision is effective October 1, 1984, the date that paragraph (38) was added to the Social Security Act.

4. Clerical Correction Relating to Income of AFDC Family Unit (sec. 1883(b)(2)(C) of the bill)

Explanation of Provision

The bill corrects the indentation and placement of a portion of section 402(a)(38) of the Social Security Act. The provision is effective October 1, 1984, the date that paragraph (38) was added to the Act.

5. Income of a Minor AFDC Parent (sec. 1883(b)(3) of the bill)

Present Law

Section 402(a)(39) of the Social Security Act requires, that in determining the income of a minor parent (of an AFDC child) who is living with her own parents or legal guardian, the State agency must include the income of the parents or legal guardian. In deciding what age defines "minor" for this purpose, paragraph (39) cross refers to the "age selected by the State pursuant to section 406(a)(2)" (the upper age limit chosen for establishing eligibility as an AFDC child).

Explanation of Provision

This bill clarifies that for purposes of defining the age limit of parents to whom paragraph (39) applies, the age is that selected by the State for purposes of defining a dependent child, without regard to whether the minor parent is attending school. This provision makes clear that only the age limit, and not the school attendance element, was intended to be relevant to the income computation rule of paragraph (39) (thus avoiding any incentive on the part of the minor parent to drop out of school).

This provision makes a conforming change necessitated by the renumbering of the paragraphs of section 457(b) by the Deficit Reduction Act.

6. Child Support Program—Conforming Amendment (sec. 1883(b)(6) of the bill)

Explanation of Provision

7. Federal Incentive Payments in Cases of Interstate Collections (sec. 1883(b)(7) of the bill and sec. 458(d) of the Social Security Act)

Present Law

P.L. 98-378 made a number of amendments to the child support enforcement program. Several of these amendments were designed to encourage States to enforce the more complicated interstate child support obligations which arise when the custodial parent and child(ren) live in one State and the noncustodial parent lives in another State.

Section 458(d) of the Social Security Act as established by P.L. 98-378 provides that in interstate cases "support which is collected by one State on behalf of individuals residing in another State shall be treated as having been collected in full by each such State." As a result, in interstate collection efforts, both States are to be credited with the collection for the purposes of calculating the incentive payment.

Explanation of Provision

The bill clarifies the intent of Congress that the incentive be credited to both the State initiating the collection and the State making the collection. It describes the initiating State as the State requesting the collection, rather than the State of residence of the individuals on whose behalf the collection is made. The change is necessary because the State of residence is not always the same as the State initiating the collection request.

8. Exclusion from AFDC Unit of Siblings Receiving Foster Care Maintenance Payments (sec. 1883(b)(9) of the bill)

Present Law

Prior to the addition of the family unit rule in AFDC (section 402(a)(38)) by the Deficit Reduction Act, a sibling of an AFDC child, residing in the AFDC household but receiving foster care maintenance payments under part E of title IV of the Act, was excluded from the AFDC family unit.

Explanation of Provision

The bill adds a new section to part E of title IV to make clear that the sibling (of an AFDC child) receiving foster care maintenance payments is not a member of the AFDC unit. This provision assures that, by authorizing foster care payment in a separate part E, rather than under the predecessor section 408 of the AFDC program, no change will occur in the treatment of the various individuals concerned.

This provision is effective October 1, 1984, the date upon which the AFDC family unit rule (which caused the question to arise) became effective.

C. Technical Corrections to Unemployment Compensation Program

- 1. Limitation on the Federal Unemployment Tax Act (FUTA) Credit in States Meeting the Solvency Requirements of Section 1202 of the Social Security Act (sec. 1884 of the bill and sec. 3302(f) of the Code)**

Present Law

Under present law, States can borrow funds from the Federal Unemployment account if they have insufficient funds in their own unemployment accounts to pay unemployment benefits. Depending on the month in which such a loan is advanced, a State has between 22 and 34 months to repay the loan. If the loan is not repaid in time, the FUTA tax credit for employers in the State is reduced by .3% for each year the loan is in arrears.

The Social Security Act Amendments of 1983 provided for a partial limitation on the FUTA credit reduction in States that take legislative steps to improve the solvency of their unemployment insurance systems. If States meet the solvency test, the FUTA credit reduction is limited to .1% a year for each year a State has a loan in arrears. This limitation on the FUTA credit reduction is in effect for calendar years 1983, 1984 and 1985.

Explanation of Provision

The bill clarifies that the limitation on the FUTA credit reduction in States meeting the solvency test of Section 1202 of the Social Security Act expires at the end of calendar year 1985.

- 2. Reference to Agricultural Crew Leaders in the Federal Unemployment Tax Act (FUTA) (sec. 1884 of the bill and sec. 3306 of the Code)**

Present Law

Section 3306(O)(A)(i) of the Internal Revenue Code provides that for purposes of the Federal Unemployment Tax Act an individual who is a member of a crew furnished by a crew leader to perform agricultural labor for any other person shall be treated as an employee of such crew leader if such crew leader holds a valid certificate of registration under the Farm Labor Contractor Act of 1963. This act has been repealed and replaced with the Migrant and Seasonal Agricultural Workers Protection Act of 1983.

Explanation of Provision

The bill strikes the reference in section 3306 of the Internal Revenue Code of 1954 to the Farm Labor Contractor Act of 1963 and

replaces it with a reference to the Migrant and Seasonal Agricultural Workers Protection Act of 1983.

D. Technical Corrections to the Child Support Enforcement Amendments of 1984

Distribution of Child Support Collections (sec. 1898 of the bill)

Present Law

Section 457(b)(3) of the Social Security Act provides that when child support is collected on behalf of an AFDC child, amounts for current support in excess of the current AFDC payment (for which the State and Federal governments may reimburse themselves), are paid to the family up to the amount of monthly support required by a court order.

Explanation of Provision

The bill changes the reference from the amount required by "court order" to "court or administrative order," to conform it with a parallel provision added to the law by the Child Support Enforcement Amendments of 1984 to use administrative processes for establishing support obligations. This provision is effective on enactment.

**TECHNICAL CORRECTIONS TO THE CONSOLIDATED OMNIBUS BUDGET
RECONCILIATION ACT OF 1985**

Technical Corrections to Customs User Fees

1. Amendment Relating to Fee on Passengers (sec. 1893(a) of the bill and sec. 13031(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985)

The bill clarifies that the \$5 fee for passengers arriving in the United States shall not be collected from passengers in transit to a destination outside the United States where the passenger does not pass through Customs inspectional services.

2. Amendment Relating to Overtime Provided by U.S. Customs at Foreign Preclearance Facilities (sec. 1893(b) of the bill and sec. 13031(e)(1) of the Consolidated Omnibus Budget Reconciliation Act of 1985)

The bill clarifies that overtime customs services are to be provided at no cost to airlines or airline passengers in connection with the pre-clearance of scheduled airline flights where pre-clearance takes the place of Customs inspection upon the arrival of such airline flights in the United States.

3. Amendment Relating to Remittance of Fees (sec. 1893(c) of the bill and sec. 13031(g) of the Consolidated Omnibus Budget Reconciliation Act of 1985)

The bill specifies that Customs user fees are to be collected and remitted to the Customs Service through procedures comparable to those already in place for the collection and remittance to the Internal Revenue Service of the tax on the use of international travel facilities.

4. Amendment Relating to Overtime Charges for Inspectional Services Other Than Those Performed for Customs Purposes (sec. 1893(d) of the bill, sec. 13031(h)(2) of the Consolidated Omnibus Budget Reconciliation Act of 1985, and sec. 53 of the Airport and Airway Development Act of 1970)

The bill clarifies that overtime charges incurred for inspectional services of the Federal Government, other than Customs, such as for agricultural and immigration inspections, are not affected by the changes made by the Customs user fee provision. Such overtime services are to be reimbursed on the same basis as was the case prior to the enactment of section 13031 of the Consolidated Omnibus Budget Reconciliation Act of 1985.

B. Medicare and Medicaid Technical Corrections (sec. 1895 of the bill, secs. 1866, 1842, 1902, 1903, and 1920 of the Social Security Act, and secs. 9127, 9202, 9221, 9517, and 9528 of the Consolidated Omnibus Budget Reconciliation Act of 1985)

The bill makes miscellaneous technical corrections to the Social Security Act and the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272). The corrections will be effective as if the corrected provisions had been originally included in, or amended by, P.L. 99-272.

TAX REFORM ACT OF 1986

CONFERENCE REPORT

TO ACCOMPANY

H.R. 3838



Volume I of 2 Volumes

SEPTEMBER 18, 1986.—Ordered to be printed

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3838) to reform the internal revenue laws of the United States, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment struck out all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment which is a substitute for the House bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary for agreements reached by the conferees, and minor drafting and clarifying changes.

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TAX REFORM ACT OF 1986

SEPTEMBER 18, 1986.—Ordered to be printed

Mr. ROSTENKOWSKI, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 3838]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3838) to reform the internal revenue laws of the United States, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) *SHORT TITLE.*—This Act may be cited as the “Tax Reform Act of 1986”.

(b) *TABLE OF CONTENTS.*—

TITLE I—INDIVIDUAL INCOME TAX PROVISIONS

Subtitle A—Rate Reductions; Increase in Standard Deduction and Personal Exemptions

Sec. 101. *Rate reductions.*

Sec. 102. *Increase in standard deduction.*

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Sec. 111. *Increase in earned income credit.*

Sec. 112. *Repeal of credit for contributions to candidates for public office.*

Subtitle C—Provisions Related to Exclusions

Sec. 121. *Taxation of unemployment compensation.*

Sec. 122. *Prizes and awards.*

Sec. 123. *Scholarships.*

Subtitle D—Provisions Related to Deductions

- Sec. 131. Repeal of deduction for 2-earner married couples.*
- Sec. 132. 2-percent floor on miscellaneous itemized deductions.*
- Sec. 133. Medical expense deduction limitation increased.*
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Subtitle E—Miscellaneous Provisions

- Sec. 141. Repeal of income averaging.*
- Sec. 142. Limitations on deductions for meals, travel, and entertainment.*
- Sec. 143. Changes in treatment of hobby loss, etc.*
- Sec. 144. Deduction for mortgage interest and real property taxes allowable where parsonage allowance or military housing allowance received.*

Subtitle F—Effective Dates

- Sec. 151. Effective dates.*

TITLE II—PROVISIONS RELATING TO CAPITAL COST

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- Sec. 201. Modification of accelerated cost recovery system.*
- Sec. 202. Expensing of depreciable assets.*
- Sec. 203. Effective dates; general transitional rules.*

Subtitle B—Repeal of Regular Investment Tax Credit

- Sec. 211. Repeal of regular investment tax credit.*
- Sec. 212. Effective 15-year carryback of existing carryforwards of steel companies.*
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Subtitle C—General Business Credit Reduction

- Sec. 221. Reduction in tax liability which may be offset by business credit from 85 percent to 75 percent.*

Subtitle D—Research and Development Provisions

- Sec. 231. Amendments relating to credit for increasing research activities.*
- Sec. 232. Extension of credit for clinical testing expenses for certain drugs.*

Subtitle E—Changes in Certain Amortization Provisions

- Sec. 241. Repeal of 5-year amortization of trademark and trade name expenditures.*
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- Sec. 252. Low-income housing credit.*

Subtitle G—Merchant Marine Capital Construction Funds

- Sec. 261. Provisions relating to merchant marine capital construction funds.*

TITLE III—CAPITAL GAINS

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- Sec. 302. 28-percent capital gains rate for taxpayers other than corporations.*

Subtitle B—Repeal of Corporate Capital Gains Treatment

- Sec. 311. Repeal of corporate capital gains treatment.*

Subtitle C—Incentive Stock Options

- Sec. 321. Repeal of requirement that incentive stock options are exercisable only in chronological order; modification of \$100,000 limitation.*

Subtitle D—Straddles

Sec. 331. Year-end rule expanded.

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Sec. 402. Repeal of special treatment for expenditures for clearing land.

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- Sec. 1002. *Exclusion from income with respect to structured settlements limited to cases involving physical injury.*
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- Sec. 1897. Correction of clerical error in amendments to coal tax.

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- Sec. 1898. Technical corrections to the Retirement Equity Act of 1984.

**CHAPTER 3—AMENDMENT RELATED TO THE CHILD SUPPORT ENFORCEMENT
AMENDMENTS OF 1984**

Sec. 1899. Amendment related to the Child Support Enforcement Amendments of 1984.

**CHAPTER 4—MISCELLANEOUS AMENDMENTS CORRECTING ERRORS OF SPELLING,
PUNCTUATION, ETC.**

Sec. 1899A. Miscellaneous amendments correcting errors of spelling, punctuation, etc.

SEC. 2. INTERNAL REVENUE CODE OF 1986.

(a) **REDESIGNATION OF 1954 CODE.**—*The Internal Revenue Title enacted August 16, 1954, as heretofore, hereby, or hereafter amended, may be cited as the "Internal Revenue Code of 1986".*

(b) **REFERENCES IN LAWS, ETC.**—*Except when inappropriate, any reference in any law, Executive order, or other document—*

(1) to the Internal Revenue Code of 1954 shall include a reference to the Internal Revenue Code of 1986, and

(2) to the Internal Revenue Code of 1986 shall include a reference to the provisions of law formerly known as the Internal Revenue Code of 1954.

SEC. 3. AMENDMENT OF 1986 CODE; COORDINATION WITH SECTION 15.

(a) **AMENDMENT OF 1986 CODE.**—*Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.*

(b) **COORDINATION WITH SECTION 15.**—

(1) IN GENERAL.—*Except as provided in paragraph (2), for purposes of section 15 of the Internal Revenue Code of 1986, no amendment or repeal made by this Act shall be treated as a change in the rate of a tax imposed by chapter 1 of such Code.*

(2) EXCEPTION.—*Paragraph (1) shall not apply to the amendment made by section 601 (relating to corporate rate reductions).*

TITLE I—INDIVIDUAL INCOME TAX PROVISIONS

Subtitle A—Rate Reductions; Increase in Standard Deduction and Personal Exemptions

SEC. 101. RATE REDUCTIONS.

(a) **GENERAL RULE.**—*Section 1 (relating to tax imposed on individuals) is amended to read as follows:*

"SECTION 1. TAX IMPOSED.

"(a) MARRIED INDIVIDUALS FILING JOINT RETURNS AND SURVIVING SPOUSES.—*There is hereby imposed on the taxable income of—*

"(1) every married individual (as defined in section 7703) who makes a single return jointly with his spouse under section 6013, and

*"(2) every surviving spouse (as defined in section 2(a)),
a tax determined in accordance with the following table:*

(74) *The table of sections for subchapter G of chapter 32 is amended by striking out "references" in the item relating to section 4227 and inserting in lieu thereof "reference".*

(75) *The table of sections for chapter 43 is amended by—*

(A) inserting "section" before "403(b)" in the item relating to section 4973, and

(B) striking out "and allocations" in the item relating to section 4978.

And the Senate agree to the same.

DAN ROSTENKOWSKI,
J.J. PICKLE,
CHARLES B. RANGEL,
PETE STARK,
RICHARD A. GEPHARDT,
MARTY RUSSO,
DONALD J. PEASE,
JOHN J. DUNCAN,
GUY VANDER JAGT,

Managers on the Part of the House.

BOB PACKWOOD,
BOB DOLE,
JOHN H. CHAFEE,
RUSSELL B. LONG,
LLOYD BENTSEN,
SPARK M. MATSUNAGA,
BILL BRADLEY
DANIEL PATRICK MOYNIHAN,

Managers on the Part of the Senate.

○

TAX REFORM ACT OF 1986

CONFERENCE REPORT

TO ACCOMPANY

H.R. 3838



Volume II of 2 Volumes

SEPTEMBER 18, 1986.—Ordered to be printed

program and is accredited by a nationally recognized accreditation agency.

The amendments made by the conference agreement are effective for taxable years beginning on or after January 1, 1987, except that present law continues to apply to scholarships and fellowships granted before August 17, 1986. Under this rule, in the case of a scholarship or fellowship granted after August 16, 1986 and before January 1, 1987, any amount of such scholarship or fellowship grant that is received prior to January 1, 1987 and is attributable to expenditures incurred prior to January 1, 1987 (such as tuition, room, and board attributable to the period prior to January 1, 1987) is eligible for the present-law exclusion under section 117.

The conference agreement also clarifies that only for purposes of the rule that a child eligible to be claimed as a dependent on the return of his or her parents may use the standard deduction only to offset the greater of \$500 or earned income (see I.A.3., above), any amount of a noncompensatory scholarship or fellowship grant that is includible in gross income as a result of these amendments to section 117 (including the repeal of any section 117 exclusion for nondegree candidates) constitutes earned income. (Amounts received as payment for teaching or other services also constitute earned income.)

3. Prizes and awards

Present Law

Scientific, etc. achievement awards.—Prizes and awards received by the taxpayer, other than scholarships and fellowship grants excludable under section 117, generally are includible in gross income (sec. 74(a)). However, a limited exclusion applies for prizes and awards (other than scholarships or fellowship grants) received for achievements in fields such as the sciences, charity, or the arts, but only if the recipient (1) has not applied specifically for the prize or award (e.g., by entering a contest), and (2) is not required to render services as a condition of receiving it (sec. 74(b)).

Employee awards.—Section 61 provides that “gross income means all income from whatever source derived,” including compensation for services whether in the form of cash, fringe benefits, or similar items. However, an item transferred from an employer to an employee, other than a prize or award that is includible under section 74, may be excludable from gross income if it qualifies as a gift under section 102.

The U.S. Supreme Court, in a case involving payments made “in a context with business overtones,” has defined excludable gifts as payments made out of “detached and disinterested generosity” and not in return for past or future services or from motives of anticipated benefit (*Comm’r v. Duberstein*, 363 U.S. 278 (1960)). Under this standard, the Court said, transfers made in connection with employment constitute gifts only in the “extraordinary” instance.

If an award to an employee constitutes a gift excludable from income under section 102, the employer’s deduction is limited pursuant to section 274(b). That provision generally disallows business deductions for gifts to the extent that the total cost of all gifts of cash, tangible personal property, and other items to the same indi-

vidual from the taxpayer during the taxable year exceeds \$25. Under an exception to the \$25 limitation, the ceiling on the deduction is \$400 in the case of an excludable gift of an item of tangible personal property awarded to an employee for length of service, safety achievement, or productivity. In addition, the ceiling on the employer's business gift deduction is \$1,600 for an excludable employee award for such purposes when provided under a qualified award plan, if the average cost of all plan awards in the year does not exceed \$400.

Section 132(e) excludes from income certain de minimis fringe benefits, i.e., any property or service the value of which is so small (taking into account the frequency with which similar fringes are provided by the employer to the employer's employees) as to make accounting for it unreasonable or administratively impracticable.

House Bill

Scientific, etc. achievement awards.—The House bill repeals the limited exclusion under present law (sec. 74(b)) for prizes or awards for scientific, etc. achievement, except where the recipient assigns the prize or award to a governmental unit (sec. 170(c)(1)) or tax-exempt charitable organization (sec. 170(c)(2)). If a qualifying assignment is made, the prize or award is not included in the winner's gross income, and no charitable deduction is allowed to the winner or to the payor. This provision is effective for taxable years beginning after December 31, 1985.

Employee awards.—Under the House bill, employee awards are not excludable from the recipient's income either under section 74 or under section 102. (In conformity with this rule, the present-law deduction limitation provisions in sec. 274(b) are repealed.) The committee report clarifies that employee awards of low value (such as certain traditional retirement gifts) are excludable if qualifying as de minimis fringe benefits as defined in section 132(e).

This provision is effective for taxable years beginning after December 31, 1985.

Senate Amendment

Scientific, etc. achievement awards.—The Senate amendment is the same as the House bill, except that the provision is effective for taxable years beginning after December 31, 1986.

Employee awards.—Under the Senate amendment, employee awards of tangible personal property for length of service or safety achievement are excludable by the employee from gross income for income tax purposes, and are deductible by the employer, to the extent that during the year the aggregate cost of awards (safety and length of service) made to the same employee does not exceed \$1,600 for all awards and \$400 for all awards that are not qualified plan awards, subject to certain additional requirements, limitations, and computation rules. To the extent that the new exclusion does not apply, all prizes or awards by employers to employees are includible in gross income other than (as under the House bill) items of low value that are excludable as de minimis fringe benefits (as defined in sec. 132(e)). The latter term would include, for example, (1) a pin or similar item with a value of \$15 awarded to

an employee on joining a business, on completing six months' employment, or on completing a probationary employment period, and (2) a traditional retirement gift presented to an employee on his or her retirement after completing lengthy service. The new employee achievement award exclusion is not available for any award made by a sole-proprietorship to the sole-proprietor.

This provision is effective for taxable years beginning after December 31, 1986.

Conference Agreement

Scientific, etc. achievement awards.—The conference agreement follows the Senate amendment, effective for such awards made after December 31, 1986.

Employee awards.—The conference agreement follows the Senate amendment, with a modification that an employee award is excludable from wages for employment tax purposes and from the social security benefit base to the same extent that the award is excludable under the conference agreement from gross income for income tax purposes. The conference agreement is effective for such awards made after December 31, 1986.

legal services and to make a new election to take group legal services instead. Such revocation and new election must be made no later than 60 days after the date of enactment and may relate to any period after December 31, 1985. This transition rule is limited to cafeteria plans that, prior to the date of conference action, did not allow employees to elect group legal services benefits with respect to a period after December 31, 1985.

4. Treatment of Certain Full-Time Life Insurance Salespersons

Present Law

Under a cafeteria plan, an employee is offered a choice between cash and one or more employee benefits. If certain requirements are met, then the mere availability of cash or certain permitted taxable benefits under a cafeteria plan does not cause an employee to be treated as having received the available cash or taxable benefits for income tax purposes.

Under present law, a full-time life insurance salesperson is treated as an employee for purposes of eligibility for certain enumerated employee benefit exclusions (sec. 7701(a)(20)). However, although such a salesperson is eligible to receive certain excludable employee benefits that may be provided under a cafeteria plan, the salesperson is not treated as an employee for purposes of the cafeteria plan provisions.

House Bill

The House bill permits a full-time life insurance salesperson to be treated as an employee for purposes of the cafeteria plan provisions to the extent the salesperson is otherwise permitted to exclude from income the benefit elected.

The provision applies for years beginning after December 31, 1985.

Senate Amendment

No provision.

Conference Agreement

The conference agreement follows the House bill.

5. Exclusion of Cafeteria Plan Elective Contributions From Wages for Purposes of Employment Taxes

Present Law

No amount is included in the gross income of a participant in a cafeteria plan meeting certain requirements solely because, under the plan, the participant may choose among the benefits of the plan. However, the fact that remuneration is not subject to income tax withholding does not necessarily mean that such remuneration is not subject to tax under the Federal Insurance Contributions Act (FICA) or under the Federal Unemployment Tax Act (FUTA). Both the FICA and FUTA taxes apply to all remuneration for employment, with certain exceptions. There is no provision with re-

spect to either the FICA or the FUTA which would render inapplicable the principles of constructive receipt.

House Bill

No provision.

Senate Amendment

No provision.

Conference Agreement

The conference agreement clarifies that the cafeteria plan exception from the principles of constructive receipt also applies for purposes of the FICA and FUTA taxes. This clarification does not apply to elective contributions under a qualified cash or deferred arrangement that is part of a cafeteria plan.

The provision is effective with respect to years beginning before, on, or after the date of enactment.

6. Exclusion for Post-Retirement Group-Term Life Insurance Under a Cafeteria Plan

Present Law

The cost of permanent benefits under a life insurance policy provided by an employer to an employee is includible in income. In general, a permanent benefit is a benefit with an economic value extending beyond one policy year, such as a paid-up policy for future years.

No amount is includible in the gross income of a participant in a cafeteria plan meeting certain requirements solely because, under the plan, the participant may choose among the benefits. Except with respect to elective contributions under a qualified cash or deferred arrangement, the term "cafeteria plan" does not include any plan which provides for deferred compensation.

House Bill

No provision.

Senate Amendment

No provision.

Conference Agreement

Under the conference agreement, with respect to employees of educational institutions (within the meaning of section 170(b)(1)(A)(ii)), a cafeteria plan may allow participants to choose among cash, qualified benefits, or post-retirement life insurance coverage that meets certain conditions. The coverage would have to be fully paid up upon retirement and have no cash surrender value at any time prior to retirement from the service of the employer.

In addition, the conference agreement provides that such coverage shall be treated as term insurance for purposes of the exclusion for group-term life insurance.

line. He may also require that all persons who must register post bond. In addition, the Secretary may register industrial users of gasoline blend stocks or additives as terminal operators permitting them to purchase such products in bulk form tax free. The Treasury Department is directed to study the incidence of evasion of the gasoline tax and to report to the Congress by December 31, 1986.

D. Social Security and FUTA Provisions

1. Allow ministers to reelect social security coverage

Present Law

The Federal Insurance Contributions Act (FICA) imposes separate payroll taxes on employers and employees equal to a percentage of wages paid as remuneration for employment. For self-employed individuals, a similar tax is imposed on self-employment income under the Self-Employment Contributions Act (SECA). These taxes are used to fund social security programs.

As a general rule, ministers of a church, members of religious orders, and Christian Science practitioners ("ministers") are treated as self-employed individuals for purposes of SECA taxes, even if otherwise they would be classified as employees (secs. 1402(c), 3121(b)(8)). However, a minister who is conscientiously, or because of religious principles, opposed to participation in a public insurance system generally may elect to be exempt from social security coverage and SECA taxes by filing with the IRS an irrevocable application for such exemption within two years of beginning the ministry (sec. 1402(e)).

House Bill

No provision.

Senate Amendment

The Senate amendment provides a limited period (generally, up to April 15, 1988) during which a minister who previously had elected out of social security coverage may make an irrevocable election back into social security coverage. An electing minister becomes subject to SECA tax, and his or her post-election earnings are credited for social security benefit purposes.

The Senate amendment also provides that a minister of a church or member of a religious order who files an application (after 1986) for exemption from social security coverage and SECA taxes on religious or conscientious grounds must include with the application a statement that he or she has informed the ordaining, commissioning, or licensing body of the church or order that he or she is opposed to the acceptance of public insurance benefits based on ministerial service. The Senate amendment also provides that an exemption application from a minister may be approved by the Treasury Department only if, subsequent to receiving the application, it separately verifies (in-person or by telephone communication) that the applicant is aware of the grounds for exemption and seeks exemption on such grounds. The Treasury Department may enter into an agreement with the Secretary of Health and Human

Services (HHS) pursuant to which such verification may be made by HHS.

Conference Agreement

The conference agreement generally follows the Senate amendment. Under the conference agreement, Treasury regulations are to provide that exemption applications filed with the IRS (after 1986) are to include information showing that the applicant has informed the church body or order of his or her religious or conscientious opposition to social security coverage, in conformity with the revised exemption procedure. The regulations may provide procedures under which, pursuant to agreement between the Secretary of the Treasury and the Secretary of Health and Human Services, HHS has the responsibility of communicating with the applicant in order to make the separate verification required as a prerequisite for approving the exemption application. The conference agreement does not require that the subsequent verification be in-person or by telephone communication, but the verification procedure must be effective to establish that the applicant is aware of the grounds for exemption from the social security system and has sought an irrevocable exemption on such grounds. Under these procedures, the disclosure of information to HHS by the IRS concerning a ministerial exemption application for such verification purposes is authorized by Code section 6103(1)(1).

2. Common paymaster rule for FICA and FUTA taxes

Present Law

The Federal Insurance Contributions Act (FICA) imposes payroll taxes on employers and employees. For 1986, the employer's FICA tax is 7.15 percent of wages paid to the employee up to \$42,000. Similarly, the Federal Unemployment Tax Act (FUTA) imposes a tax on an employer with respect to all its employees. The FUTA tax is 0.8 percent on the first \$7,000 of wages.

In general, when the same individual is employed by two or more employers, each employer is subject to the FICA and FUTA tax on the base wages of the individual. An exception applies where two or more related corporations concurrently employ the same individual and compensate him or her through a common paymaster, i.e., one of the related corporations. Under this exception, payroll taxes are determined as though the individual has only one employer, the common paymaster. As a result, the taxes are applied against only a single base amount of wages.

House Bill

No provision.

Senate Amendment

The Senate amendment extends the common-paymaster exception for purposes of collection of FICA and FUTA taxes to the case where the same employee works for related corporations and/or partnerships. The same test used for determining related corpora-

tions is employed to determine whether a partnership is related. This provision is effective for wages paid or incurred after December 31, 1986.

Conference Agreement

The conference agreement does not include the Senate amendment.

3. Agricultural wages subject to FUTA

Present Law

The Federal unemployment tax (FUTA) applies to wages of workers in agricultural operations with a payroll of at least \$20,000 in any calendar quarter, or with 10 or more employees in 20 weeks of the year (sec. 3306(c)(1)).

House Bill

No provision.

Senate Amendment

Under the Senate amendment, the quarterly payroll threshold at which agricultural wages are subject to FUTA tax is increased from \$20,000 to \$40,000, effective for wages paid after September 30, 1986.

Conference Agreement

The conference agreement does not include the Senate amendment.

4. FUTA for certain Indian tribal governments

Present Law

Generally, Indian tribal governments are treated as any other employer and are subject to Federal unemployment tax (FUTA). No exception is provided if unemployment compensation coverage is denied by the State in which the employer conducts business. Certain Indian tribal governments have been denied unemployment compensation coverage by the State of Colorado and are not required to pay State unemployment compensation taxes.

House Bill

No provision.

Senate Amendment

The Senate amendment provides an exemption from FUTA tax for Indian tribal governments the service for which was not covered by a State unemployment compensation program on June 11, 1986. This provision is effective for services performed before January 1, 1988, including services performed prior to the date of enactment (but does not authorize a refund of any previously paid FUTA tax). It is anticipated that the State of Colorado and the affected

effect of the provision cannot be avoided by claims that such technical service personnel are employees of personal service corporations controlled by such personnel. For example, an engineer retained by a technical services firm to provide services to a manufacturer cannot avoid the effect of this provision by organizing a corporation that he or she controls and then claiming to provide services as an employee of that corporation.

This provision does not affect the application of Code section 414(n), relating to employee leasing, to technical services personnel in circumstances where that provision applies under present law. Also, the provision does not apply with respect to individuals who are classified, under the generally applicable common law standards, as employees of a business that is a client of the technical services firm.

Conference Agreement

The conference agreement follows the Senate amendment with a technical modification clarifying the language of the Senate amendment to conform to the language of section 530 of the Revenue Act of 1978 and with an amendment to the effective date. The conferees further clarify that the provision does not affect the application of the Treasury's authority under Code section 414(o) to prevent avoidance of certain employee benefit requirements. The conferees believe that the provision will provide more consistent tax treatment of individuals performing services in the technical service industry.

The conference agreement is effective for remuneration paid and services performed after December 31, 1986.

6. Payroll tax deposits

Present Law

The manner and time for depositing an employer's FICA taxes and the income and FICA taxes withheld from employees are specified in Treasury regulations (sec. 6302). If the aggregate amount of undeposited taxes totals \$3,000 or more at the end of any one-eighth-monthly period, the employer must deposit the taxes within three banking days of the close of the one-eighth-monthly period (Reg. sec. 31.6302(c)-1).

House Bill

No provision.

Senate Amendment

The Senate amendment increases from \$3,000 to \$5,000 the amount of undeposited payroll taxes an employer may aggregate before the one-eighth-monthly deposit rule applies, effective for months beginning after December 31, 1986.

Conference Agreement

The conference agreement does not include the Senate amendment.

F. Tax Code Revisions

1. Reference to Internal Revenue Code

Present Law

The current tax code (title 26 of the U.S. Code) is referred to as the "Internal Revenue Code of 1954, as amended" or the "1954 Code."

The 1954 Code provides that no provision of the statute is to apply if it would be contrary to any treaty obligation of the United States in effect on the date of enactment of the 1954 Code (sec. 7852(d)).

House Bill

The House bill enacts into law the Internal Revenue Code of 1985. That is, the bill reenacts the provisions of the 1954 Code—as in effect on the date of enactment of the bill—together with amendments as made by the bill. The committee report states that this reenactment is not intended to change any substantive provisions of the tax law not otherwise modified by this bill.

The bill also provides that no provision of the Internal Revenue title that was in effect on August 16, 1954 shall apply in any case where its application would be contrary to any treaty obligation of the United States in effect on the date of enactment of the 1954 Code. This provision is intended to clarify that treaty provisions that were in effect in 1954 and that conflict with the 1954 Code as originally enacted are to prevail over then-existing statutes, but not over later-enacted statutes, and that treaty benefits that are now properly available under the 1954 Code will remain available under the 1985 Code.

Senate Amendment

No provision.

Conference Agreement

Under the conference agreement, the "short title" of the tax statute is the Internal Revenue Code of 1986.

A number of provisions of the conference agreement provide that the Secretary of the Treasury or his delegate is to prescribe regulations. Notwithstanding any of these references, the conferees intend that the Treasury may, prior to prescribing these regulations, issue guidance for taxpayers with respect to the provisions of the conference agreement by issuing Revenue Procedures, Revenue Rulings, forms and instructions to forms, announcements, or other publications or releases. The conferees expect that the Treasury will provide taxpayers with this guidance as soon as feasible.

2. Moratorium on major tax revisions

Present Law

No provision.

4. Information on special or unique tax treatment

Present Law

No provision.

House Bill

No provision.

Senate Amendment

The Senate amendment includes a sense of the Senate resolution that the conference report on the bill should contain the name of any business concern or group receiving special or unique treatment, and the reason for and cost of such treatment.

Conference Agreement

The conference agreement does not include the Senate amendment.

5. Certain quality control studies for AFDC and Medicaid

Present Law

Under section 12301 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Department of Health and Human Services (HHS) and the National Academy of Sciences (NAS) are required to undertake a study of quality control measures in connection with the administration of the Aid to Families with Dependent Children and Medicaid programs. HHS and NAS are required to report the results of their study to the Congress within one year of the date of enactment of COBRA (April 7, 1986). In addition, HHS is required to publish certain regulations relating to such quality control measures within 18 months of the date of enactment of COBRA.

House Bill

No provision.

Senate Amendment

The Senate amendment requires HHS and NAS to report the results of their quality control study within one year after contracting to undertake the study. The date by which HHS is required to publish the specified regulations is six months after the deadline for reporting the results of the quality control study to the Congress.

Conference Agreement

The conference agreement follows the Senate amendment.

TITLE XVIII. TECHNICAL CORRECTIONS

House Bill

The House bill contains technical, clerical, and conforming amendments to the Tax Reform Act of 1984 and other recently enacted tax legislation, as well as similar amendments to nontax provisions of the Deficit Reduction Act of 1984. The Committee on Ways and Means previously favorably reported H.R. 2110 (H. Rep. 99-526, Part 1), containing technical corrections to the Retirement Equity Act of 1984. The provisions in H.R. 2110 as so reported are referred to herein as being in the House bill.

Senate Amendment

The Senate amendment contains technical, clerical, and conforming amendments to the Tax Reform Act of 1984, the Retirement Equity Act of 1984 and other recently enacted tax legislation, as well as similar amendments to nontax provisions of the Deficit Reduction Act of 1984 and the Consolidated Omnibus Budget Reconciliation Act of 1985.

Conference Agreement

The conference agreement follows the House bill and the Senate amendment with respect to common provisions. Specifically, the conference agreement includes the following provisions:

The Tax Reform Act of 1984

Deferral of certain tax reductions

The conference agreement follows the Senate amendment.

Tax-exempt entity leasing

The conference agreement follows the Senate amendment except that the provision relating to subsidiary organizations applies to property placed in service after September 27, 1985.

Debt instruments

The conference agreement follows the Senate amendment except that the provision relating to amortization of bond premiums applies to bonds issued after September 27, 1985; the provision requiring accrual of interest on certain short term obligations applies to obligations acquired after September 27, 1985; and the agreement contains the provision in the House bill clarifying the effective date for the repeal of the capital asset requirement.

Tax-exempt bonds

The conference agreement contains the provisions in the House bill and also the provisions in the Senate amendment, with a modification providing that the sunset date for the exception from the private loan bond restriction is August 15, 1986. The conferees wish to restate that the provision of the House bill with regard to the specificity required for certain volume cap carryforward elections is to be self-implementing rather than an authorization of Treasury action.

Miscellaneous provisions

The conference agreement contains the provisions in the House bill and also contains the provisions in the Senate amendment.

Partnership audit provision

The conference agreement coordinates the Tax Court deficiency procedures with respect to partner level determinations arising from a partnership proceeding with the deficiency procedures applicable to the taxpayer from items unrelated to a partnership proceeding.

Windfall profit tax provision

The House bill and the Senate amendment clarify that the term "newly discovered oil" includes production from a property so long as not more than 2,200 barrels was produced from the property in 1978 and no well on the property was in production for more than 72 hours during that year (whether or not the oil was sold). For purposes of this test, a dual completion well shall be treated as two separate wells, i.e., one well for each horizon. This provision is intended to clarify the "test well" exception described in the Conference Report accompanying the Crude Oil Windfall Profit Tax Act of 1980. No inference is intended as to the application of similar principles in areas other than section 4991(e)(2).

*Social Security, Medicare, AFDC, Child Support, SSI, Social Services**Social Security amendments*

The conference agreement follows the Senate amendment.

Revocation of certain church elections

It is intended that the regulations allowing a church or qualified church-controlled organization to revoke an election made under Code section 3121(w)(2) are to provide that any such revocation is not to be effective prior to January 1, 1987, unless such electing church or organization had withheld and paid over all employment taxes due, as if such election had never been in effect, during the period from the stated effective date of the election being revoked through December 31, 1986.

Medicare

The conference agreement follows the Senate amendment.

AFDC and child support

The conference agreement is as follows.

a. Stepparent work disregard.—The conference agreement follows the Senate amendment, which repeals the authority for a lower disregard in the case of part-time employment effective October 1, 1984.

b. Standard filing unit.—The conference agreement includes that portion of the Senate amendment which clarifies that the standard filing unit provision applies to the AFDC-UP program. The change is effective October 1, 1984. The agreement does not include that portion of the Senate amendment concerning Title II benefits and certain child support payments. No inference is intended with regard to current Federal regulations implementing section 402(a)(38) of the Social Security Act.

c. Definition of minor parent.—The conference agreement follows the Senate amendment, which clarifies that the definition of minor parent is based only on age, not on school attendance. The agreement also clarifies that to be considered a minor parent, an individual must be under 18 years of age.

d. Treatment of foster care payments.—The conference agreement follows the Senate amendment which clarifies that a child receiving foster care maintenance payments shall not be considered a member of the family when determining AFDC eligibility and benefits.

e. Distribution of child support collections.—The conference agreement follows the Senate amendment which clarifies that the rules regarding distribution of child support collections apply to child support paid as a result of a court order or an administrative order.

General Social Security Act provisions, SSI and Social Services

The conference agreement follows the House bill and the Senate amendment.

Effective Date of Social Security Act Amendments

The conference agreement follows the House bill and the Senate amendment. With regard to those amendments with an effective date of October 1, 1984, paragraphs (1), (2), (3) and (9) of section 1883(b) of the Senate amendment, no State shall be considered to have failed to comply with the Social Security Act or to have made overpayments or underpayments by reason of its compliance or noncompliance with these amendments for the period beginning October 1, 1984 and ending on the day preceding the date of enactment of this Act.

Unemployment compensation

The conference agreement follows the House bill and the Senate amendment.

Trade and tariff programs

The conference agreement includes the provisions in the House bill and also includes the provisions in the Senate amendment,

*Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**Continuing health care*

The conference agreement adopts the following technical corrections to the continuing health care provisions of COBRA.

a. Notification requirement.—The conference agreement establishes a 60-day notification period for divorced or legally separated spouses of covered employees, or dependent children ceasing to be dependent children under the generally applicable requirements of the plan, to notify the plan administrator of a qualifying event entitling the spouse or dependent children to continuation health coverage.

b. Maximum period of continuation coverage.—The conference agreement clarifies that a qualified beneficiary may have more than one qualifying event which entitles the beneficiary to continuation coverage, but in no event may the coverage period with respect to such events generally exceed a 36-month period. The second qualifying event must take place during the period of coverage of the first qualifying event to be eligible for a total of 36 months continuation coverage beginning from the date of the first qualifying event.

c. Election of coverage.—The conference agreement clarifies that each qualified beneficiary is entitled to a separate election of continuation coverage. For example, if a covered employee does not elect continuation coverage, the conferees intend that the spouse or dependent children are entitled to elect such coverage. Moreover, even if the employee elects certain coverage, the spouse or dependents may elect different coverage.

d. Failure to pay premium.—The conference agreement provides that the grace period for the failure to pay premiums is the longest of (1) 30 days, (2) the period the plan allows employees for failure to pay premiums, or (3) the period the insurance company allows the plan or the employer for failure to pay premiums.

e. Type of coverage.—The conference agreement provides that, for all purposes, qualified beneficiaries are to be treated under the plan in the same manner as similarly situated beneficiaries for whom a qualifying event has not taken place. For example, if the plan provides for an open enrollment period, then qualified beneficiaries are to be permitted to make elections during the open enrollment period in the same manner as active employees. Thus, an individual who is a qualified beneficiary by reason of being a spouse of a covered employee would have the same rights as active employees during an open enrollment period and would not be limited to the rights of spouses of covered employees.

The conference agreement defines health benefits to mean health benefit plans, including dental and vision care (within the meaning of sec. 213 of the Code). The conferees do not intend that an employer could compel a qualified beneficiary to pay for noncore benefits (such as dental and vision care) even if active employees are required to purchase coverage for such benefits under the plan.

Medicare

The conference agreement follows the Senate amendment with the following clarifications: (1) correct and clarify the section re-

DAN ROSTENKOWSKI,
J.J. PICKLE,
CHARLES B. RANGEL,
PETE STARK,
RICHARD A. GEPHARDT,
MARTY RUSSO,
DONALD J. PEASE,
JOHN J. DUNCAN,

Managers on the part of the House.

BOB PACKWOOD,
BOB DOLE,
JOHN H. CHAFEE,
RUSSELL B. LONG,
LLOYD BENTSEN,
SPARK MATSUNAGA,
GUY VANDER JAGT,
BILL BRADLEY,
DANIEL PATRICK MOYNIHAN,

Managers on the part of the Senate.



Finder's Aid
P.L. 99-570 (100 Stat. 3207) Approved October 27, 1986
Anti-Drug Abuse Act of 1986

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>S.Rep. 99-411</u>
Supplemental Security Income - Treatment of Homeless Individuals	1631(e)(3) New	11005(a)	3207-169	—
Supplemental Security Income - Pre-Release Procedures for Institutionalized Individuals	1631(j) New	11006	3207-169	—
Medicaid - Treatment of Homeless Individuals (technical amendment)	1902(a)(45)	11005(b)(1)	3207-169	—
Medicaid - Treatment of Homeless Individuals (technical amendment)	1902(a)(46)	11005(b)(2)	3207-169	—
Medicaid - Treatment of Homeless Individuals	1902(a)(47) New	11005(b)(3)	3207-169	—

***Public Law 99-570**
99th Congress

An Act

To strengthen Federal efforts to encourage foreign cooperation in eradicating illicit drug crops and in halting international drug traffic, to improve enforcement of Federal drug laws and enhance interdiction of illicit drug shipments, to provide strong Federal leadership in establishing effective drug abuse prevention and education programs, to expand Federal support for drug abuse treatment and rehabilitation efforts, and for other purposes.

Oct. 27, 1986

[H.R. 5484]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Anti-Drug Abuse
 Act of 1986.
 21 USC 801 note.

SECTION 1. SHORT TITLE.

This Act may be cited as the “Anti-Drug Abuse Act of 1986”.

SEC. 2. ORGANIZATION OF ACT.

This Act is organized as follows:

TITLE I—ANTI-DRUG ENFORCEMENT

Subtitle A—Narcotics Penalties and Enforcement Act of 1986

Subtitle B—Drug Possession Penalty Act of 1986

Subtitle C—Juvenile Drug Trafficking Act of 1986

Subtitle D—Assets Forfeiture Amendments Act of 1986

Subtitle E—Controlled Substance Analogue Enforcement Act of 1986

Subtitle F—Continuing Drug Enterprise Act of 1986

Subtitle G—Controlled Substances Import and Export Act Penalties Enhancement Act of 1986

Subtitle H—Money Laundering Control Act of 1986

Subtitle I—Armed Career Criminals

Subtitle J—Authorization of Appropriations for Drug Law Enforcement

Subtitle K—State and Local Narcotics Control Assistance

Subtitle L—Study on the Use of Existing Federal Buildings as Prisons

Subtitle M—Narcotics Traffickers Deportation Act

Subtitle N—Freedom of Information Act

Subtitle O—Prohibition on the Interstate Sale and Transportation of Drug Paraphernalia

Subtitle P—Manufacturing Operations

Subtitle Q—Controlled Substances Technical Amendments

Subtitle R—Precursor and Essential Chemical Review

Subtitle S—White House Conference for a Drug Free America

Subtitle T—Common Carrier Operation Under the Influence of Alcohol or Drugs

Subtitle U—Federal Drug Law Enforcement Agent Protection Act of 1986

*Note: This is a subsequently typeset print of the hand enrollment which was signed by the President on October 27, 1986.

TITLE II—INTERNATIONAL NARCOTICS CONTROL

TITLE III—INTERDICTION

Subtitle A—Department of Defense Drug Interdiction Assistance

Subtitle B—Customs Enforcement

Subtitle C—Maritime Drug Law Enforcement Prosecution Improvements Act of 1986

Subtitle D—Coast Guard

Subtitle E—United States Bahamas Drug Interdiction Task Force

Subtitle F—Command, Control, Communications, and Intelligence Centers

Subtitle G—Transportation Safety

Subtitle H—Department of Justice Funds for Drug Interdiction Operation in Hawaii

Subtitle I—Federal Communications Commission

TITLE IV—DEMAND REDUCTION

Subtitle A—Treatment and Rehabilitation

Subtitle B—Drug-Free Schools and Communities Act of 1986

Subtitle C—Indians and Alaska Natives

Subtitle D—Miscellaneous Provisions

TITLE V—UNITED STATES INSULAR AREAS AND NATIONAL PARKS

Subtitle A—Programs in United States Insular Areas

Subtitle B—National Park Service Program

TITLE VI—FEDERAL EMPLOYEE SUBSTANCE ABUSE EDUCATION AND TREATMENT

TITLE VII—NATIONAL ANTIDRUG REORGANIZATION AND COORDINATION

TITLE VIII—PRESIDENT'S MEDIA COMMISSION ON ALCOHOL AND DRUG ABUSE PREVENTION

TITLE IX—DENIAL OF TRADE BENEFITS TO UNCOOPERATIVE MAJOR DRUG PRODUCING OR DRUG-TRANSIT COUNTRIES

TITLE X—BALLISTIC KNIFE PROHIBITION

TITLE XI—HOMELESS ELIGIBILITY CLARIFICATION ACT

Subtitle A—Emergency Food for the Homeless

Subtitle B—Job Training for the Homeless

Subtitle C—Entitlements Eligibility

TITLE XII—COMMERCIAL MOTOR VEHICLE SAFETY ACT OF 1986

TITLE XIII—CYANIDE WRONGFUL USE

TITLE XIV—SENATE POLICY CONCERNING FUNDING

TITLE XV—NATIONAL FOREST SYSTEM DRUG CONTROL

21 USC 801 note.

SEC. 3. COMPLIANCE WITH BUDGET ACT.

Notwithstanding any other provision of this Act, any spending authority and any credit authority provided under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts. For purposes of this Act, the

(b) **BARRIERS TO EMPLOYMENT RULE.**—Section 203(a)(2) of the Job Training Partnership Act (29 U.S.C. 1603(a)(2)) is amended by striking out “or addicts” and inserting in lieu thereof “addicts, or homeless”.

Subtitle C—Entitlements Eligibility

SEC. 11005. TREATMENT OF HOMELESS INDIVIDUALS ELIGIBLE UNDER SSI AND MEDICAID PROGRAMS.

(a) **SSI PROGRAM.**—Section 1631(e) of the Social Security Act (42 U.S.C. 1383(e)) is amended by adding at the end the following new paragraph:

“(3) The Secretary shall provide a method of making payments under this title to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.”.

(b) **MEDICAID PROGRAM.**—Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended—

(1) by striking “and” at the end of paragraph (45),

(2) by striking the period at the end of paragraph (46) and inserting in lieu thereof “; and”, and

(3) by adding at the end the following new paragraph:

“(47) provide a method of making cards evidencing eligibility for medical assistance available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.”.

(c) **EFFECTIVE DATE.**—(1) The amendment made by subsection (a) shall become effective on the date of the enactment of this Act

(2) The amendments made by subsection (b) shall become effective on January 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(d) **AFDC.**—No later than six months after the date of enactment of this act and after consultation with the States administering plans under Title IV of the Social Security Act, the Secretary of Health and Human Services shall issue guidelines to the States for providing benefits under Title IV to a dependent child who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

SEC. 11006. APPLICATION FOR SSI AND FOOD STAMP BENEFITS BY SSI PRE-RELEASE INDIVIDUALS.

Section 1631 of the Social Security Act (42 U.S.C. 1383) is amended by adding at the end thereof the following new subsection:

“PRE-RELEASE PROCEDURES FOR INSTITUTIONALIZED PERSONS

“(j) The Secretary shall develop a system under which an individual can apply for supplemental security income benefits under this title prior to the discharge or release of the individual from a public institution. The Secretary and the Secretary of Agriculture shall develop a procedure under which an individual who applies for supplemental security income benefits under this title shall also be permitted to apply for participation in the food stamp program by executing a single application.”.

42 USC 1383
note.

42 USC 1396aa
note.

State and local
governments.
42 USC 602 note.
42 USC 601.

relating to marijuana and other controlled substances, and State drug control laws or ordinances, within the boundaries of the National Forest System.

SEC. 15005. PENALTY.

Section 401 of the Controlled Substances Act (21 U.S.C. 841) is amended by adding at the end thereof the following subsection:

“(e)(1) Any person who assembles, maintains, places, or causes to be placed a boobytrap on Federal property where a controlled substance is being manufactured, distributed, or dispensed shall be sentenced to a term of imprisonment for not more than 10 years and shall be fined not more than \$10,000.

“(2) If any person commits such a violation after 1 or more prior convictions for an offense punishable under this subsection, such person shall be sentenced to a term of imprisonment of not more than 20 years and shall be fined not more than \$20,000.

“(3) For the purposes of this subsection, the term ‘boobytrap’ means any concealed or camouflaged device designed to cause bodily injury when triggered by any action of any unsuspecting person making contact with the device. Such term includes guns, ammunition, or explosive devices attached to trip wires or other triggering mechanisms, sharpened stakes, and lines or wires with hooks attached.”.

SEC. 15006. AUTHORIZATION OF APPROPRIATIONS.

16 USC 559e.

There is authorized to be appropriated \$10,000,000 for each fiscal year to carry out this title.

SEC. 15007. APPROVAL OF SECRETARY OF AGRICULTURE AND ATTORNEY GENERAL.

16 USC 559f.

The authorities conferred herein shall be exercised pursuant to an agreement approved by the Secretary of Agriculture and the Attorney General.

Approved October 27, 1986.

LEGISLATIVE HISTORY—H.R. 5484 (S. 1903):

SENATE REPORTS: No. 99-411 accompanying S. 1903 (Comm. on Commerce, Science, and Transportation).

CONGRESSIONAL RECORD, Vol. 132 (1986):

Sept. 10, 11, considered and passed House.

Sept. 26, 27, 30, considered and passed Senate, amended.

Oct. 8, House concurred in Senate amendments with an amendment.

Oct. 10, 14, 15, Senate concurred in House amendments with amendments.

Oct. 17, House concurred in Senate amendments with an amendment; Senate concurred in House amendment.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 22 (1986):

Oct. 27, Presidential statement and remarks.

THE COMMERCIAL MOTOR VEHICLE SAFETY ACT OF 1986

AUGUST 15 (legislative day, AUGUST 11), 1986.—Ordered to be printed

Mr. DANFORTH, from the Committee on Commerce, Science, and Transportation, submitted the following

REPORT

[To accompany S. 1903]

The Committee on Commerce, Science, and Transportation, to which was referred the bill (S. 1903) to improve the safe operation of commercial motor vehicles, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill do pass.

PURPOSE OF THE BILL

The purpose of the bill is to help prevent truck and bus accidents, fatalities and injuries by establishing national standards for commercial drivers' licenses and requiring drivers to have a single commercial license and driving record; by increasing safety inspections of commercial motor vehicles and inspections of their drivers for alcohol and drug use; and by increasing and extending authorizations for State grants through the Motor Carrier Safety Assistance Program (MCSAP).

BACKGROUND AND NEEDS

Motor carrier safety is an issue of continuing concern to the Committee. The Committee has conducted numerous hearings and reported legislation on this issue in the 95th through the 99th Congresses.

In 1982, a major step was taken to improve motor carrier safety with the enactment of the Surface Transportation Assistance Act of 1982 (Public Law 97-424). This act authorized a total of more than \$150 million over fiscal years 1983 through 1988 to enable the Department of Transportation (DOT) to provide grants to States for enforcement of Federal and compatible State motor carrier safety regulations, which became MCSAP. Under this program, 49 States

No material re Social Security in this report.

Finder's Aid
P.L. 99-576 (100 Stat. 3248) Approved October 28, 1986
"Veterans' Benefits Improvement and
Health-Care Authorization Act of 1986"

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-730</u>	<u>S.Rep. 99-444</u>
Medicare - Agreements with Providers - Participation in Veterans Administration Contract Program (technical amendment)	1866(a)(1) (J)	233(a)(1)	3265	—	15, 162
Medicare - Agreements with Providers - Participation in Veterans Administration Contract Program (technical amendment)	1866(a)(1) (K)	233(a)(2)	3265	—	15, 162
Medicare - Agreements with Providers of Services - Participation in Veterans Administration Contract Program	1866(a)(1) (L) New	233(a)(3)	3265	—	15, 59, 102, 160

PUBLIC LAW 99-576—OCT. 28, 1986

**VETERANS' BENEFITS IMPROVEMENT
AND HEALTH-CARE AUTHORIZATION
ACT OF 1986**

Public Law 99-576
99th Congress

An Act

Oct. 28, 1986
[H.R. 5299]

Veterans'
Benefits
Improvement
and Health-Care
Authorization
Act of 1986.
38 USC 101 note.

To amend title 38, United States Code, to increase the rates of compensation and dependency and indemnity compensation for veterans and survivors, and to improve veterans' health-care, education, employment, housing, and national cemetery programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; REFERENCES TO TITLE 38, UNITED STATES CODE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Veterans' Benefits Improvement and Health-Care Authorization Act of 1986".

(b) REFERENCES TO TITLE 38.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

(c) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

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- Sec. 102. Additional compensation for dependents.
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TITLE I—COMPENSATION INCREASES AND OTHER COMPENSATION MATTERS

SEC. 101. DISABILITY COMPENSATION.

(a) IN GENERAL.—Section 314 is amended—

- (1) by striking out “\$68” in subsection (a) and inserting in lieu thereof “\$69”;
- (2) by striking out “\$126” in subsection (b) and inserting in lieu thereof “\$128”;
- (3) by striking out “\$191” in subsection (c) and inserting in lieu thereof “\$194”;
- (4) by striking out “\$274” in subsection (d) and inserting in lieu thereof “\$278”;
- (5) by striking out “\$388” in subsection (e) and inserting in lieu thereof “\$394”;
- (6) by striking out “\$489” in subsection (f) and inserting in lieu thereof “\$496”;
- (7) by striking out “\$617” in subsection (g) and inserting in lieu thereof “\$626”;
- (8) by striking out “\$713” in subsection (h) and inserting in lieu thereof “\$724”;
- (9) by striking out “\$803” in subsection (i) and inserting in lieu thereof “\$815”;
- (10) by striking out “\$1,335” in subsection (j) and inserting in lieu thereof “\$1,355”;
- (11) by striking out “\$62”, “\$1,659”, and “\$2,325” in subsection (k) and inserting in lieu thereof “\$63”, “\$1,684”, and “\$2,360”, respectively;
- (12) by striking out “\$1,659” in subsection (l) and inserting in lieu thereof “\$1,684”;

include in the Registry, to the extent feasible, such veteran's name and the data and information described in subsection (b) relating to the veteran.

(d) **CONSOLIDATION OF EXISTING INFORMATION.**—(1) For the purpose of establishing and maintaining the Registry, the Administrator shall compile and consolidate—

(A) relevant information maintained by the Department of Veterans' Benefits and the Department of Medicine and Surgery of the Veterans' Administration;

(B) relevant information maintained by the Defense Nuclear Agency of the Department of Defense; and

(C) any relevant information maintained by any other element of the Veterans' Administration or the Department of Defense.

(2) With respect to a veteran whose name is included in the Registry and for whom the information in the Registry is not complete, the Administrator shall include information described in paragraph (1) with respect to that veteran (A) to the extent that such information is reasonably available in records of the Veterans' Administration or Department of Defense, or (B) if such information is submitted by the veteran after the enactment of this Act.

(e) **DEPARTMENT OF DEFENSE INFORMATION.**—The Secretary of Defense shall furnish to the Administrator such information maintained by the Department of Defense as the Administrator considers necessary to establish and maintain the Registry.

(f) **DEFINITION.**—For the purpose of this section, the term "veteran" has the meaning given that term in section 101(2) of title 38, United States Code, and includes a person who died in the active military, naval, or air service.

38 USC 101.

(g) **EFFECTIVE DATE.**—The Registry shall be established not later than 180 days after the date of the enactment of this Act.

SEC. 233. REQUIREMENT FOR MEDICARE HOSPITALS TO PARTICIPATE IN VETERANS' ADMINISTRATION CONTRACT HEALTH-CARE PROGRAM.

(a) **IN GENERAL.**—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)), as amended by section 1895(b) of the Tax Reform Act of 1986, is amended—

Ante, p. 2931.

(1) by striking out "and" at the end of subparagraph (J);

(2) by striking out the period at the end of subparagraph (K) and inserting in lieu thereof ", and"; and

(3) by inserting after subparagraph (K) the following new subparagraph:

"(L) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under section 603 of title 38, United States Code, in accordance with such admission practices, and such payment methodology and amounts, as are prescribed under joint regulations issued by the Secretary and by the Administrator of Veterans' Affairs in implementation of such section."

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to inpatient hospital services provided pursuant to admissions to hospitals occurring after June 30, 1987.

42 USC 1395cc note.

(c) **REPORT.**—(1) The Secretary of Health and Human Services shall periodically submit to the Congress a report on the number of hospitals that have terminated or failed to renew an agreement

42 USC 1395cc note.

amended by striking out "413" and inserting in lieu thereof "413(a)".

(2) Section 111(c)(1)(B) of such Act is amended by striking out "subsection (b)" and inserting in lieu thereof "subsection (c)(1)(B)" 38 USC 363 note.

(b) AMENDMENTS TO TITLE 38.—(1) Section 524 of title 38, United States Code, is amended—

(A) by striking out "subsection (d)" in subsection (a)(2) and inserting in lieu thereof "subsection (b)";

(B) by striking out "subsection (a)(1)" in subsection (b)(4) and inserting in lieu thereof "subsection (a)"; and

(C) in subsection (c)—

(i) by striking out "Notwithstanding subsection (c) of section 525 of this title, a veteran" and inserting in lieu thereof "A veteran";

(ii) by striking out "subsection (b)" the second place it appears and inserting in lieu thereof "subsection (b)(1)"; and

(iii) by striking out the period and inserting in lieu thereof "without regard to the date on which the veteran's entitlement to pension is terminated."

(2) Section 525(a) of such title is amended by striking out "under section 521 of this title".

(3) The item relating to section 524 in the table of sections at the beginning of chapter 15 of such title is amended by inserting "program of" after "Temporary".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the Veterans' Benefits Improvement Act of 1984 (Public Law 98-543). 38 USC 413 note.
38 USC 101 note.

Approved October 28, 1986.

LEGISLATIVE HISTORY—H.R. 5299 (S. 2422):

HOUSE REPORTS: No. 99-730 (Comm. on Veterans' Affairs).

SENATE REPORTS: No. 99-444 accompanying S. 2422 (Comm. on Veterans' Affairs).

CONGRESSIONAL RECORD, Vol. 132 (1986):

Aug. 4, considered and passed House.

Sept. 30, considered and passed Senate, amended, in lieu of S. 2422.

Oct. 7, House concurred in Senate amendments with amendments.

Oct. 8, Senate concurred in House amendments.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 22 (1986):

Oct. 28, Presidential remarks.

VETERANS' COMPENSATION AMENDMENTS OF 1986

JULY 31, 1986.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. MONTGOMERY, from the Committee on Veterans' Affairs,
submitted the following

REPORT

[To accompany H.R. 5299]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 5299) to amend title 38, United States Code, to provide a 2.0 percent increase in the rates of compensation and of dependency and indemnity compensation (DIC) paid by the Veterans' Administration, and for other purposes, having considered the same, report favorably thereon without amendment by unanimous voice vote and recommend that the bill do pass.

INTRODUCTION

The administration's proposed fiscal year 1987 budget request submitted earlier this year recommended a 3.7 percent cost-of-living allowance (COLA) for the service-connected disability compensation and DIC programs. The 3.7 percent rate adjustment represented the increase that was anticipated, at that time, for the indexed non-service-connected pension program, based on the changes in the Consumer Price Index (CPI) from the third quarter of calendar year 1985 to the third quarter of calendar year 1986. The increase proposed by the administration would become effective December 1, 1986.

In its report to the Committee on the Budget (February 27, 1986), the committee recommended that the First Concurrent Budget Resolution contain new budget authority and outlays for a 3.7 percent increase effective December 1, 1986. The resolution, as passed by the House, included a 3.4 percent increase based on the then current economic assumptions. The conference agreement on the pro-

No material re Social Security in this report.

99TH CONGRESS }
2d Session }

SENATE

{ REPORT
{ 99-444

OMNIBUS VETERANS' BENEFITS IMPROVEMENT AND
HEALTH CARE AUTHORIZATION ACT OF 1986

REPORT

OF THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

TO ACCOMPANY

S. 2422



SEPTEMBER 16 (legislative day, SEPTEMBER 15), 1986.—Ordered to be printed

COMMITTEE ON VETERANS' AFFAIRS

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ANTHONY J. PRINCIPI, *Chief Counsel/Staff Director*

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(1) Subject to subsection (c), a list containing the name of each veteran who was exposed to ionizing radiation under the conditions described in section 610(e)(1)(B) of title 38, United States Code, and—

(A) who has applied for hospital or nursing home care from the Veterans' Administration under such title; or

(B) who has filed a claim for compensation under chapter 11 of such title on the basis of a disability which may be associated with the exposure to ionizing radiation; or

(C) who has died and is survived by a spouse, child, or parent who has filed a claim for dependency and indemnity compensation under chapter 13 of such title; on the basis of the exposure of such veteran to ionizing radiation.

(2) Medical data relating to each veteran listed in the Registry under paragraph (1), including the veteran's medical history and health status recorded by the Veterans' Administration including the results of physical examinations by the Veterans' Administration, and a statement describing birth defects, if any, in the natural children of the veteran.

(3) Data on claims for the benefits referred to in paragraph (1), including decisions and determinations of the Veterans' Administration relating to such claims.

(4) An estimate of the dose of radiation to which each veteran listed in the Registry under paragraph (1) was exposed under the conditions described in section 610(e)(1)(B) of such title.

(c) **NAMES NOT REQUIRED TO BE INCLUDED.**—The Administrator is not required to include in the Registry the name of a veteran described in subsection (b)(1) if the request or claim referred to in subsection (b)(1) which relates to such veteran was filed before the date of the enactment of this Act and such veteran or the survivor filing the claim (in the case of a claim referred to in clause (C) of subsection (b)(1)), does not request the Veterans' Administration to include the veteran's name in the Registry.

(d) **CONSOLIDATION OF EXISTING INFORMATION.**—For the purpose of establishing and maintaining the Registry, the Administrator of Veterans' Affairs shall compile and consolidate relevant information maintained by the Department of Veterans' Benefits, the Department of Medicine and Surgery, and the Board of Veterans' Appeals of the Veterans' Administration, relevant information maintained by the Defense Nuclear Agency of the Department of Defense, and relevant information maintained by any other subdivision of the Veterans' Administration or the Department of Defense.

(e) **DEPARTMENT OF DEFENSE INFORMATION.**—The Secretary of Defense shall furnish the Administrator such information maintained by any agency of the Department of Defense as the Administrator considers necessary to establish and maintain the Registry.

(f) **DEFINITION.**—For the purpose of this section, the term "veteran" shall have the meaning provided in section 101(2) of title 38, United States Code, and shall also include a person who died in the active military, naval, or air service.

SEC. 213. AUTHORITY TO WAIVE LICENSURE AND INTERNSHIP REQUIREMENTS FOR RESEARCH PSYCHOLOGISTS

Clause (8) of section 4105(a) is amended by striking out "may" and all that follows through "and" at the end of such clause and inserting in lieu thereof the following:

"may, on a case-by-case basis—

"(A) waive the requirement of licensure or certification for a psychologist for a period not to exceed 2 years on the condition that such psychologist provide patient care only under the direct supervision of a psychologist who is so licensed or certified; and

"(B) waive the requirements of internship and of licensure or certification for a psychologist who is to be employed to conduct research and is to have no responsibility for furnishing direct patient-care services; and".

SEC. 214. REQUIREMENT FOR MEDICARE HOSPITALS TO PARTICIPATE IN VETERANS' ADMINISTRATION CONTRACT HEALTH-CARE PROGRAM

(a) **IN GENERAL.**—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(1) by striking out "and" at the end of subparagraph (I);

(2) by striking out the period at the end of subparagraph (J) and inserting in lieu thereof a comma and "and"; and

(3) by inserting after subparagraph (J) the following new subparagraph:

"(K) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under section 603 of title 38, United States Code, in accordance with such admission practices, and such payment methodology and amounts, as are prescribed under joint regulations issued by the Secretary and by the Administrator of Veterans' Affairs in implementation of such section."

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

(c) **REPORT.**—The Secretary of Health and Human Services shall report to the Congress periodically on the number of hospitals that have terminated or failed to renew an agreement under section 1866 of the Social Security Act as a result of the additional conditions imposed under the amendments made by subsection (a).

(2) Not later than April 1, 1987, the Administrator of Veterans' Affairs shall report to the Committees on Veterans' Affairs of the Senate and the House of Representatives regarding implementation of this section and shall thereafter notify such committees in the event that any hospital terminates or fails to renew an agreement described in paragraph (1) for the reasons therein described.

SEC. 215. ORGANIZATION OF THE DEPARTMENT OF MEDICINE AND SURGERY

(a) **OFFICE OF THE CHIEF MEDICAL DIRECTOR.**—Section 4103(a) is amended—

(1) by inserting "persons, each of whom shall be qualified in the administration of health services" after "following";

(2) in clause (3)—

(A) by striking out "The" and inserting in lieu thereof "Two";

(B) by striking out "Director" the first place it appears and inserting in lieu thereof "Directors";

(C) by striking out "an assistant" and inserting in lieu thereof "assistants";

(D) by striking out "shall be a qualified doctor of medicine" and inserting in lieu thereof "both shall be persons with specified qualifications"; and

(E) by adding at the end the following new sentence: "Not more than one Associate Deputy Chief Medical Director may be a person who is a person with specified qualifications solely by reason of clause (ii) of the last sentence of this subsection.";

(3) in clause (4)—

(A) by striking out "shall be" the first place it appears and inserting in lieu thereof "all shall be persons with specified qualifications.";

(B) by striking out "qualified in the administration of health services who are not doctors of medicine, dental surgery, or dental medicines" and inserting in lieu thereof "who are persons with specified qualifications solely by reason of clause (ii) of the last sentence of this subsection"; and

(C) by striking out "qualified physician" and inserting in lieu thereof "person with specified qualifications";

(4) in clause (5)—

(A) by inserting a comma and "all of whom shall be persons with specified qualifications," after "Directors";

(B) by striking out the comma after "Administrator" and "Director", respectively"; and

(C) by striking out the second sentence;

(5) in clause (6), by inserting "upon the recommendation of the Chief Medical Director" after "Administrator";

(6) in clause (7)—

(A) by inserting a comma and "each of whom shall be licensed in the appropriate service field" after "Optometric Service"; and

(B) by inserting "upon the recommendation of the Chief Medical Director" after "Administrator"; and

(7) by adding at the end the following new sentence:

"For the purpose of this subsection, the term 'person with specified qualifications' means (i) a person meeting the requirements set forth in clause (1), (2), (3), (5), (6), (7), or (8) of subsection (a) of section 4105 of this title, or (ii) a person who meets or has met the requirements set forth in clause (4) of such subsection."

(b) **TECHNICAL AMENDMENT.**—Clause (3) of section 4103(b) is amended by inserting a comma after "reappointed" and after "extended", respectively, and by striking out the comma after "reappointment".

care responsibilities. The Committee bill does not include a provision addressing the VA recommendation that the VA be authorized to hire research psychologists using only term appointments because it is the Committee's understanding that the VA already has the authority under section 4114 of title 38 to hire such personnel on a temporary full-time basis and that authority should be sufficient to meet the VA's objectives in this area.

Requirement for Medicare Hospitals to Participate in Veterans' Administration Contract Health-Care Program

Section 214 of the Committee bill, which is derived from S. 2174 (legislation requested by the Administration), would require non-Federal hospitals receiving Medicare payments to accept as payment for VA fee-basis patients amounts to be determined by the Secretary of Health and Human Services (HHS) and the Administrator of Veterans' Affairs.

Background

On July 23, 1985, the VA submitted proposed legislation to amend title 38 to require that non-Federal providers of hospital care and services receiving direct payment of Medicare funds for services to Medicare beneficiaries provide similar services to VA beneficiaries under similar VA payment policies. A provision based on this legislation was incorporated into section 10024 of H.R. 3500, the proposed "Omnibus Budget Reconciliation Act of 1985" as reported by the House Budget Committee (H. Rept. No. 99-300) and passed by the House on October 24, 1985. During the House and Senate conference on the reconciliation legislation, certain concerns were raised concerning possible implementation difficulties, including questions related to the complexities involved in determining Medicare payments, especially for capital costs, and the provision was not included in the conference agreement that was subsequently enacted as Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

The Committee considered these issues during its May 20 hearing on issues relating to VA benefits and health care. The VA was strongly supportive of the measure and in general the major veterans' service organizations expressed support for S. 2174. After a review of the testimony, and following a review of the COBRA provisions requiring Medicare—participating hospitals to participate in the CHAMPUS and CHAMPVA programs and to accept payment made under both programs as payment in full, the Committee made certain modifications to S. 2174. These changes were designed primarily to require that the regulations implementing this provision be developed jointly by the Secretary of HHS and the Administrator, which should help to ensure that the provision can be implemented successfully.

Committee bill

The Committee bill would amend section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) to require the Administrator of Veterans' Affairs and the Secretary of Health and Human Services to establish, by joint regulations, a fee schedule whereby all non-

Federal hospitals which receive Medicare payments would be required to accept as payment for VA fee-basis patients the rate established by the aforementioned regulations. The authority to remove a provider from eligibility to receive Medicare payments would reside with the Secretary. The Committee intends for the Administrator to identify hospitals which fail to meet the new additional condition of participation in the VA fee-basis program and to convey that information to the Secretary for appropriate action. The Committee has consulted with the Finance Committee staff which has expressed no objection to this provision as long as it is placed in the Social Security Act. The Committee notes that this approach is modeled on the COBRA provision relating to DOD programs.

The Secretary of Health and Human Services would be required to submit to Congress periodically a report on the number of hospitals that have failed to renew, or that have terminated, their Medicare agreements with the Department of Health and Human Services as a result of this new requirement.

The VA would be required to report to the House and Senate Veterans' Affairs Committees by April 1, 1987, on the implementation of this provision. In addition, the VA would be required to notify the Committee when a hospital fails to renew or terminate a contract as described above.

The provision would apply to inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

Organization of the Department of Medicine and Surgery

Section 215 of the Committee bill would amend section 4103 of title 38, relating to the organization of the Office of the Chief Medical Director (CMD), so as to establish one new position in that office, provide new flexibility in the appointment of individuals to other positions in the CMD's office, and to make various technical changes in the section.

Committee bill

This section of the Committee bill is derived in part from S. 2172 as introduced by Chairman Murkowski on March 11 at the request of the Administration. The provision derived from that bill would establish a second Associate Deputy Chief Medical Director (ADCMD) as an assistant to the Chief Medical Director (CMD) and the Deputy CMD. The establishment of this position would enable the VA to carry out fully a reorganization of the CMD's office which was first proposed last year. As part of that reorganization, the former, single ADCMD position would be divided into two positions—an ADCMD for Operations, responsible for overseeing current operations of DM&S (currently this responsibility is carried out by a Director of Operations), and an ADCMD for Program Development and Planning, responsible for overseeing planning and program management matters.

A second principal category of changes which would be made by this provision would authorize the Administrator to appoint, in addition to physicians, certain non-physician health-care profession-

ed in section 101(2) of title 38 and also include a person who died on active duty.

Section 213

Would amend clause (8) of present section 4105(a) of title 38, relating to the qualifications that a psychologist must have—generally a doctoral degree, an internship, and a State license—in order to be eligible for appointment in the VA's Department of Medicine and Surgery, so as to authorize the waiver, on a case-by-case basis, of the internship and licensure requirements for a psychologist to be employed to conduct research who is to have no responsibility for the furnishing of patient-care services.

Section 214

Subsection (a) of section 214 would amend present section 1866 (a)(1) of the Social Security Act, relating to the terms to which hospitals must agree in order to receive Medicare payment for inpatient care provided to Medicare beneficiaries, to add a new subparagraph (k) to require the hospitals to agree to provide care under section 603 of title 38, relating to the VA's contract-care authority, in accordance with the admission practices and payment methodology and amounts that the Secretary of Health and Human Services (HHS) and the Administrator of Veterans' Affairs prescribe in implementation of section 603. This new subparagraph is patterned after a subparagraph (i) of Social Security Act section 1866(a)(1), which requires that hospitals participating in the Medicare program agree to accept Department of Defense contract-care patients in accordance with the terms prescribed in joint regulations promulgated by the Secretaries of HHS and of Defense.

Subsection (b) of section 214 would provide that subsection (a) of this section of the Committee bill shall apply to agreements entered into or renewed after the date of enactment, but not to any inpatient services provided pursuant to admissions that occur prior to January 1, 1987.

Paragraph (1) of subsection (c) of section 214 would require the Secretary of HHS to report to the Congress periodically on the number of hospitals that terminate or fail to renew their agreements under Social Security Act section 1866 (i.e., cease their participation in the Medicare program) as a result of the additional conditions imposed under the amendments made from subsection (a) of this section of the Committee bill (discussed above).

Paragraph (2) of subsection (c) of section 214 would require the Administrator, not later than April 1, 1987, to report to the Senate and House Committees on Veterans' Affairs regarding implementation of this section and thereafter notify the Committees in the event that any hospital terminates or fails to renew its Medicare agreement under Social Security Act section 1866.

Section 215

Subsection (a) of section 215 would amend subsection (a) of present section 4103, relating to the organization and staffing of the Office of the VA's Chief Medical Director, to make changes in the descriptions of the qualifications for certain positions in that office.

ance with the priority established for such projects pursuant to subsection (b) of this section.

(b) *The Administrator shall prescribe regulations to establish criteria and procedures for determining the priority to be accorded to State home facilities construction projects with respect to which applications have been approved under section 5035 of this title.*

* * * * *

Subchapter IV—Sharing of Medical Facilities, Equipment, and Information

* * * * *

§ 5053. Specialized medical resources

(a) * * *

* * * * *

(e) *The Administrator shall submit to the Congress not more than 60 days after the end of each fiscal year a report on the activities carried out under this section. Each report shall include (1) an appraisal on the effectiveness of the activities authorized in this section and the degree of cooperation from other sources, financial and otherwise, and (2) recommendations for the improvement or more effective administration of such activities.*

* * * * *

§ 5057. Reports to Congress

[The Administrator shall submit to the Congress not more than sixty days after the end of each fiscal year separate reports on the activities carried out under sections 5053 and 5054 of this subchapter, each report to include (1) an appraisal of the effectiveness of the programs authorized herein and the degree of cooperation from other sources, financial and otherwise, and (2) recommendations for the improvement or more effective administration of such programs.]

* * * * *

SOCIAL SECURITY ACT

* * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * *

PART C—MISCELLANEOUS PROVISIONS

* * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. [42 U.S.C. 1395cc] (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)),

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9) of section 1862(a), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title,

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person,

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this title) with respect to the provider,

(E) to release data with respect to patients of such provider upon request to an organization having a contract with the Secretary under part B of title XI as may be necessary (i) to allow such organization to carry out its functions under such contract, or (ii) to allow such organization to carry out similar review functions under any contract the organization may have with a private or public agency paying for health care in the same area with respect to patients who authorize release of such data for such purposes,

(F) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (c) or (d) of section 1886, to maintain an agreement with a utilization and quality control peer review organization (with an organization which has a contract with the Secretary under part B of title XI for the area in which the hospital is located) under which the organization will perform functions under that part with respect to the review of the validity of diagnos-

tic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1886(d)(5), with respect to inpatient hospital services for which payment may be made under part A of this title (and for purposes of payment under this title, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A, and (i) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, (ii) shall be transferred from the Federal Hospital Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, (iii) shall be not less than an amount which reflects the rates per review established in fiscal year 1982 for both direct and administrative costs (adjusted for inflation), and (iv) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1982 for direct and administrative costs (adjusted for inflation)) of such reviews,

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1886, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A but for a denial or reduction of payments under section 1886(f)(2),

(H) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1862(a)(14)) (i) that are furnished to an individual who is an inpatient of the hospital, and (ii) for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital,

(I) in the case of a hospital, to comply with the requirements of section 1867 to the extent applicable, [and]

(J) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of title 10, or under section 613 of title 38, United States Code, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of title 10, United States [Code.] Code, and

(K) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under section 603 of title 38, United States Code, in accordance with such admission practices, and such payment methodology and amounts, as are

prescribed under joint regulations issued by the Secretary and by the Administrator of Veterans' Affairs in implementation of such section.

In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of title IX is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

* * * * *



Finder's Aid

P.L. 99-603 (100 Stat. 3359) Approved November 6, 1986
 "Immigration Reform and Control Act of 1986"

Subject	S.S. Act Section	P.L. Section	100 Stat.	H.Rep.* 99-682 Part 1 & 2	H.Rep.* 99-682 Parts 3 4 & 5	S.Rep. 99-132	H.C.Rep. 99-1000
Old-Age Assistance - Payment to States - Reimbursement for Immigration Verification (technical amendment)	3(a)(4)(B) Redesig- nated as (C)	121(b)(4)	3391	1-16, 1-196	--	--	--
Old-Age Assistance - Payment to States - Reimbursement for Immigration Verification	3(a)(4)(B) New	121(b)(4)	3391	1-16, 1-68, 1-93, 1-196, 2-23	3-10	--	91
Unemployment Compensation Payment to States - Reimbursement for Immigration Verification	302(a)	121(b)(3)	3390	1-16, 1-68, 1-95, 1-197, 2-23	3-10	--	91
AFDC - State Plans - Temporary Disqualification of Certain Legalized Aliens (conforming amendment)	402(f) New	201(b)(1)	3403	1-74, 1-96, 2-24	3-5, 3-12, 3-34, 5-5, 5-7, 5-9, 5-15	--	--
AFDC - State Plans - Temporary Disqualification of Certain Newly Legalized Aliens - Agriculture Workers (conforming amendment)	402(f)(1)	302(b)(1)(A)	3422	1-74, 2-24, 2-50,	3-5, 3-7, 3-38	--	--

* Note: There are five reports from various committees of the House of Representatives. Page numbers are preceded by the numbers of the parts in which they appear.

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-682 Parts 1 & 2</u>	<u>H.Rep. 99-682 Parts 3 4 & 5</u>	<u>S.Rep. 99-132</u>	<u>H.C.Rep. 99-1000</u>

** Note: References to 210A(d)(7) in these provisions probably should be 210A(d)(6).

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	H.Rep. 99-682	H.Rep. 99-682	<u>S.Rep. 99-132</u>	<u>H.C.Rep. 99-1000</u>
				<u>Parts 1 & 2</u>	<u>Parts 3 4 & 5</u>		
Foster Care and Adoption Assistance - Temporary Disqualification of Certain Newly Legalized Aliens - Dependency of Disqualified Child	472(a)	201(b)(2) (A)	3403	—	3-34	—	—
Foster Care and Adoption Assistance - Temporary Disqualification of Certain Newly Legalized Aliens (conforming amendment)	472(a)	302(b)(2)	3422	—	—	—	—
Foster Care and Adoption Assistance - Disqualification of Certain Aliens from Certain Public Assistance (conforming amendment)	472(a)	303(e)(2)	3431	1-74	—	—	—
Foster Care and Adoption Assistance - Temporary Disqualification of Certain Newly Legalized Aliens - Dependency of Disqualified Child (conforming amendment)	473(a)(1)	201(b)(2) (B)	3403	1-74, 1-115	3-34	—	—
Aid to the Blind - Payment to States - Reimbursement for Immigration Verification (technical amendment)	1003(a)(3) (B) Redesig- nated as (C)	121(b)(4)	3391	1-16	—	—	—
Aid to the Blind - Payment to States - Reimbursement for Immigration Verification	1003(a)(3) (B) New	121(b)(4)	3391	1-16, 1-68, 1-95, 1-197, 2-23	3-8, 3-10, 5-7, 5-9	—	91
General Provisions - Income and Eligibility Verification Systems - Immigration Status (conforming amendment)	1137(a)	121(a)(1) (A)	3384	1-12, 1-66, 1-95, 1-114, 1-198, 2-23	3-8, 5-9, 5-15	—	91

** Note: References to 210A(d)(7) in these provisions probably should be 210A(d)(6).

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	H.Rep. 99-682	H.Rep. 99-682	<u>S.Rep. 99-132</u>	<u>H.C.Rep 99-1000</u>
				<u>Parts 1 & 2</u>	<u>Parts 3 4 & 5</u>		
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Aid to the Disabled - Payment to States - Reimbursement for Immigration Verification	1403(a)(3) (B) New	121(b)(4)	3391	1-16, 1-68, 1-95, 1-201, 2-23	3-10, 5-9	--	91
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Aid to the Aged, Blind, or Disabled - Payment to States - Reimbursement for Immigration Verification	1603(a)(4) (B) (State) New	121(b)(4)	3391	1-16, 1-68, 1-95, 1-202	3-10, 5-9	--	91
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Public Law 99-603
99th Congress

An Act

To amend the Immigration and Nationality Act to revise and reform the immigration laws, and for other purposes.

Nov. 6, 1986
[S. 1200]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; REFERENCES IN ACT.

(a) **SHORT TITLE.**—This Act may be cited as the “Immigration Reform and Control Act of 1986”.

(b) **AMENDMENTS TO IMMIGRATION AND NATIONALITY ACT.**—Except as otherwise specifically provided in this Act, whenever in this Act an amendment or repeal is expressed as an amendment to, or repeal of, a provision, the reference shall be deemed to be made to the Immigration and Nationality Act.

Immigration
Reform and
Control Act of
1986.
8 USC 1101 note.

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TITLE I—CONTROL OF ILLEGAL IMMIGRATION

PART A—EMPLOYMENT

SEC. 101. CONTROL OF UNLAWFUL EMPLOYMENT OF ALIENS.

(a) IN GENERAL.—

(1) NEW PROVISION.—Chapter 8 of title II is amended by inserting after section 274 (8 U.S.C. 1324) the following new section:

“UNLAWFUL EMPLOYMENT OF ALIENS

8 USC 1324a.

“SEC. 274A. (a) MAKING EMPLOYMENT OF UNAUTHORIZED ALIENS UNLAWFUL.—

“(1) IN GENERAL.—It is unlawful for a person or other entity to hire, or to recruit or refer for a fee, for employment in the United States—

“(A) an alien knowing the alien is an unauthorized alien (as defined in subsection (h)(3)) with respect to such employment, or

“(B) an individual without complying with the requirements of subsection (b).

“(2) CONTINUING EMPLOYMENT.—It is unlawful for a person or other entity, after hiring an alien for employment in accordance with paragraph (1), to continue to employ the alien in the United States knowing the alien is (or has become) an unauthorized alien with respect to such employment.

“(3) DEFENSE.—A person or entity that establishes that it has complied in good faith with the requirements of subsection (b)

"(B) Proof that any person described in paragraph (1) has diligently maintained any facility, or utilized any method, which has been approved by the Attorney General under subparagraph (A) (within the period for which the approval is effective) shall be *prima facie* evidence that such person acted diligently and reasonably to fulfill the duty imposed by subsection (a) (within the meaning of paragraph (1) of this subsection)."

SEC. 115. ENFORCEMENT OF THE IMMIGRATION LAWS OF THE UNITED STATES.

It is the sense of the Congress that—

(1) the immigration laws of the United States should be enforced vigorously and uniformly, and

(2) in the enforcement of such laws, the Attorney General shall take due and deliberate actions necessary to safeguard the constitutional rights, personal safety, and human dignity of United States citizens and aliens.

SEC. 116. RESTRICTING WARRANTLESS ENTRY IN THE CASE OF OUTDOOR AGRICULTURAL OPERATIONS.

Section 287 (8 U.S.C. 1357) is amended by adding at the end the following new subsection:

"(d) Notwithstanding any other provision of this section other than paragraph (3) of subsection (a), an officer or employee of the Service may not enter without the consent of the owner (or agent thereof) or a properly executed warrant onto the premises of a farm or other outdoor agricultural operation for the purpose of interrogating a person believed to be an alien as to the person's right to be or to remain in the United States."

SEC. 117. RESTRICTIONS ON ADJUSTMENT OF STATUS.

Section 245(c)(2) (8 U.S.C. 1255(c)(2)) is amended by inserting after "hereafter continues in or accepts unauthorized employment prior to filing an application for adjustment of status" the following: "or who is not in legal immigration status on the date of filing the application for adjustment of status or who has failed (other than through no fault of his own for technical reasons) to maintain continuously a legal status since entry into the United States".

PART C—VERIFICATION OF STATUS UNDER CERTAIN PROGRAMS

SEC. 121. VERIFICATION OF IMMIGRATION STATUS OF ALIENS APPLYING FOR BENEFITS UNDER CERTAIN PROGRAMS.

(a) REQUIRING IMMIGRATION STATUS VERIFICATION.—

(1) UNDER AFDC, MEDICAID, UNEMPLOYMENT COMPENSATION, AND FOOD STAMP PROGRAMS.—Section 1137 of the Social Security Act (42 U.S.C. 1320b-7) is amended—

(A) in the matter in subsection (a) before paragraph (1), by inserting "which meets the requirements of subsection (d) and" after "income and eligibility verification system",

(B) in subsection (b), by striking out "income verification system" in the matter preceding paragraph (1) and inserting in lieu thereof "income and eligibility verification system", and

(C) by adding at the end the following new subsections:

"(d) The requirements of this subsection, with respect to an income and eligibility verification system of a State, are as follows:

"(1)(A) The State shall require, as a condition of an individual's eligibility for benefits under any program listed in subsection (b), a declaration in writing by the individual (or, in the case of an individual who is a child, by another on the individual's behalf), under penalty of perjury, stating whether or not the individual is a citizen or national of the United States, and, if that individual is not a citizen or national of the United States, that the individual is in a satisfactory immigration status.

Children and youth.

"(B) In this subsection—

"(i) in the case of the program described in subsection (b)(1), any reference to an individual's eligibility for benefits under the program shall be considered a reference to the individual's being considered a dependent child or to the individual's being treated as a caretaker relative or other person whose needs are to be taken into account in making the determination under section 402(a)(7),

8 USC 1546.

"(ii) in the case of the program described in subsection (b)(4)—

"(I) any reference to the State shall be considered a reference to the State agency, and

"(II) any reference to an individual's eligibility for benefits under the program shall be considered a reference to the individual's eligibility to participate in the program as a member of a household, and

"(III) the term 'satisfactory immigration status' means an immigration status which does not make the individual ineligible for benefits under the applicable program.

"(2) If such an individual is not a citizen or national of the United States, there must be presented either—

"(A) alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual's alien admission number or alien file number (or numbers if the individual has more than one number), or

"(B) such other documents as the State determines constitutes reasonable evidence indicating a satisfactory immigration status.

"(3) If the documentation described in paragraph (2)(A) is presented, the State shall utilize the individual's alien file or alien admission number to verify with the Immigration and Naturalization Service the individual's immigration status through an automated or other system (designated by the Service for use with States) that—

"(A) utilizes the individual's name, file number, admission number, or other means permitting efficient verification, and

"(B) protects the individual's privacy to the maximum degree possible.

"(4) In the case of such an individual who is not a citizen or national of the United States, if, at the time of application for benefits, the statement described in paragraph (1) is submitted but the documentation required under paragraph (2) is not presented or if the documentation required under paragraph (2)(A) is presented but such documentation is not verified under paragraph (3)—

“(A) the State—

“(i) shall provide a reasonable opportunity to submit to the State evidence indicating a satisfactory immigration status, and

“(ii) may not delay, deny, reduce, or terminate the individual's eligibility for benefits under the program on the basis of the individual's immigration status until such a reasonable opportunity has been provided; and

“(B) if there are submitted documents which the State determines constitutes reasonable evidence indicating such status—

“(i) the State shall transmit to the Immigration and Naturalization Service photostatic or other similar copies of such documents for official verification,

“(ii) pending such verification, the State may not delay, deny, reduce, or terminate the individual's eligibility for benefits under the program on the basis of the individual's immigration status, and

“(iii) the State shall not be liable for the consequences of any action, delay, or failure of the Service to conduct such verification.

“(5) If the State determines, after complying with the requirements of paragraph (4), that such an individual is not in a satisfactory immigration status under the applicable program—

“(A) the State shall deny or terminate the individual's eligibility for benefits under the program, and

“(B) the applicable fair hearing process shall be made available with respect to the individual.

“(e) Each Federal agency responsible for administration of a program described in subsection (b) shall not take any compliance, disallowance, penalty, or other regulatory action against a State with respect to any error in the State's determination to make an individual eligible for benefits based on citizenship or immigration status—

“(1) if the State has provided such eligibility based on a verification of satisfactory immigration status by the Immigration and Naturalization Service,

“(2) because the State, under subsection (d)(4)(A)(ii), was required to provide a reasonable opportunity to submit documentation,

“(3) because the State, under subsection (d)(4)(B)(ii), was required to wait for the response of the Immigration and Naturalization Service to the State's request for official verification of the immigration status of the individual, or

“(4) because of a fair hearing process described in subsection (d)(5)(B).”

(2) UNDER HOUSING ASSISTANCE PROGRAMS.—Section 214 of the Housing and Community Development Act of 1980 (42 U.S.C. 1436a) is amended by adding at the end the following new subsections:

“(d) The following conditions apply with respect to financial assistance being provided for the benefit of an individual:

“(1)(A) There must be a declaration in writing by the individual (or, in the case of an individual who is a child, by another on the individual's behalf), under penalty of perjury, stating whether or not the individual is a citizen or national of the

United States, and, if that individual is not a citizen or national of the United States, that the individual is in a satisfactory immigration status.

“(B) In this subsection, the term ‘satisfactory immigration status’ means an immigration status which does not make the individual ineligible for financial assistance.

“(2) If such an individual is not a citizen or national of the United States, there must be presented either—

“(A) alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual’s alien admission number or alien file number (or numbers if the individual has more than one number), or

“(B) such other documents as the Secretary determines constitutes reasonable evidence indicating a satisfactory immigration status.

“(3) If the documentation described in paragraph (2)(A) is presented, the Secretary shall utilize the individual’s alien file or alien admission number to verify with the Immigration and Naturalization Service the individual’s immigration status through an automated or other system (designated by the Service for use with States) that—

“(A) utilizes the individual’s name, file number, admission number, or other means permitting efficient verification, and

“(B) protects the individual’s privacy to the maximum degree possible.

“(4) In the case of such an individual who is not a citizen or national of the United States, if, at the time of application for financial assistance, the statement described in paragraph (1) is submitted but the documentation required under paragraph (2) is not presented or if the documentation required under paragraph (2)(A) is presented but such documentation is not verified under paragraph (3)—

“(A) the Secretary—

“(i) shall provide a reasonable opportunity to submit to the Secretary evidence indicating a satisfactory immigration status, and

“(ii) may not delay, deny, reduce, or terminate the individual’s eligibility for financial assistance on the basis of the individual’s immigration status until such a reasonable opportunity has been provided; and

“(B) if there are submitted documents which the Secretary determines constitutes reasonable evidence indicating such status—

“(i) the Secretary shall transmit to the Immigration and Naturalization Service photostatic or other similar copies of such documents for official verification,

“(ii) pending such verification, the Secretary may not delay, deny, reduce, or terminate the individual’s eligibility for financial assistance on the basis of the individual’s immigration status, and

“(iii) the Secretary shall not be liable for the consequences of any action, delay, or failure of the Service to conduct such verification.

"(5) If the Secretary determines, after complying with the requirements of paragraph (4), that such an individual is not in a satisfactory immigration status—

"(A) the Secretary shall deny or terminate the individual's eligibility for financial assistance, and

"(B) the applicable fair hearing process shall be made available with respect to the individual.

In this subsection and subsection (e), the term 'Secretary' refers to the Secretary and to a public housing authority or other entity which makes financial assistance available.

"(e) The Secretary shall not take any compliance, disallowance, penalty, or other regulatory action against an entity with respect to any error in the entity's determination to make an individual eligible for financial assistance based on citizenship or immigration status—

"(1) if the entity has provided such eligibility based on a verification of satisfactory immigration status by the Immigration and Naturalization Service,

"(2) because the entity, under subsection (d)(4)(A)(ii), was required to provide a reasonable opportunity to submit documentation,

"(3) because the entity, under subsection (d)(4)(B)(ii), was required to wait for the response to the Immigration and Naturalization Service to the entity's request for official verification of the immigration status of the individual, or

"(4) because of a fair hearing process described in subsection (d)(5)(B)."

(3) UNDER TITLE IV EDUCATIONAL ASSISTANCE.—Section 484 of the Higher Education Act of 1965 (20 U.S.C. 1091) is amended by adding at the end the following new subsections:

"(c) The following conditions apply with respect to an individual's receipt of any grant, loan, or work assistance under this title as a student at an institution of higher education:

"(1)(A) There must be a declaration in writing to the institution by the student, under penalty of perjury, stating whether or not the student is a citizen or national of the United States, and, if the student is not a citizen or national of the United States, that the individual is in a satisfactory immigration status.

"(B) In this subsection, the term 'satisfactory immigration status' means an immigration status which does not make the student ineligible for a grant, loan, or work assistance under this title.

"(2) If the student is not a citizen or national of the United States, there must be presented to the institution either—

"(A) alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual's alien admission number or alien file number (or numbers if the individual has more than one number), or

"(B) such other documents as the institution determines (in accordance with guidelines of the Secretary) constitutes reasonable evidence indicating a satisfactory immigration status.

"(3) If the documentation described in paragraph (2)(A) is presented, the institution shall utilize the individual's alien file or alien admission number to verify with the Immigration and

Ante, p. 1480.

Grants.
Loans.

Naturalization Service the individual's immigration status through an automated or other system (designated by the Service for use with institutions) that—

“(A) utilizes the individual's name, file number, admission number, or other means permitting efficient verification, and

“(B) protects the individual's privacy to the maximum degree possible.

“(4) In the case of such an individual who is not a citizen or national of the United States, if the statement described in paragraph (1) is submitted but the documentation required under paragraph (2) is not presented or if the documentation required under paragraph (2)(A) is presented but such documentation is not verified under paragraph (3)—

“(A) the institution—

“(i) shall provide a reasonable opportunity to submit to the institution evidence indicating a satisfactory immigration status, and

“(ii) may not delay, deny, reduce, or terminate the individual's eligibility for the grant, loan, or work assistance on the basis of the individual's immigration status until such a reasonable opportunity has been provided; and

“(B) if there are submitted documents which the institution determines constitutes reasonable evidence indicating such status—

“(i) the institution shall transmit to the Immigration and Naturalization Service photostatic or other similar copies of such documents for official verification,

“(ii) pending such verification, the institution may not delay, deny, reduce, or terminate the individual's eligibility for the grant, loan, or work assistance on the basis of the individual's immigration status, and

“(iii) the institution shall not be liable for the consequences of any action, delay, or failure of the Service to conduct such verification.

“(5) If the institution determines, after complying with the requirements of paragraph (4), that such an individual is not in a satisfactory immigration status—

“(A) the institution shall deny or terminate the individual's eligibility for such grant, loan, or work assistance, and

“(B) the fair hearing process (which includes, at a minimum, the requirements of paragraph (6)) shall be made available with respect to the individual.

“(6) The minimal requirements of this paragraph for a fair hearing process are as follows:

“(A) The institution provides the individual concerned with written notice of the determination described in paragraph (5) and of the opportunity for a hearing respecting the determination.

“(B) Upon timely request by the individual, the institution provides a hearing before an official of the institution at which the individual can produce evidence of a satisfactory immigration status.

“(C) Not later than 45 days after the date of an individual's request for a hearing, the official will notify the

individual in writing of the official's decision on the appeal of the determination.

“(d) The Secretary shall not take any compliance, disallowance, penalty, or other regulatory action against an institution of higher education with respect to any error in the institution's determination to make a student eligible for a grant, loan, or work assistance based on citizenship or immigration status—

“(1) if the institution has provided such eligibility based on a verification of satisfactory immigration status by the Immigration and Naturalization Service,

“(2) because the institution, under subsection (c)(4)(A)(ii), was required to provide a reasonable opportunity to submit documentation,

“(3) because the institution, under subsection (c)(4)(B)(ii), was required to wait for the response of the Immigration and Naturalization Service to the institution's request for official verification of the immigration status of the student, or

“(4) because of a fair hearing process described in subsection (c)(5)(B).

“(e) Notwithstanding subsection (c), if—

“(1) a guaranty is made under this title for a loan made with respect to an individual,

“(2) at the time the guaranty is entered into, the provisions of subsection (c) had been complied with,

“(3) amounts are paid under the loan subject to such guaranty, and

“(4) there is a subsequent determination that, because of an unsatisfactory immigration status, the individual is not eligible for the loan,

the official of the institution making the determination shall notify and instruct the entity making the loan to cease further payments under the loan, but such guaranty shall not be voided or otherwise nullified with respect to such payments made before the date of the entity receives the notice.”.

(b) PROVIDING 100 PERCENT REIMBURSEMENT FOR COSTS OF IMPLEMENTATION AND OPERATION.—

42 USC 603.

(1) UNDER AFDC PROGRAM.—Section 403(a)(3) of the Social Security Act is amended by inserting before subparagraph (B) the following new subparagraph:

“(A) 100 percent of so much of such expenditures as are for the costs of the implementation and operation of the immigration status verification system described in section 1137(d).”.

42 USC 1396b.

(2) UNDER MEDICAID PROGRAM.—Section 1903(a) of such Act is amended by inserting after paragraph (3) the following new paragraph:

“(4) an amount equal to 100 percent of the sums expended during the quarter which are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus”.

42 USC 1320b-7.

(3) UNDER UNEMPLOYMENT COMPENSATION PROGRAM.—The first sentence of section 302(a) of such Act is amended by inserting before the period at the end the following: “, including 100 percent of so much of the reasonable expenditures of the State as are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1137(d)”.

42 USC 502.

(4) **UNDER CERTAIN TERRITORIAL ASSISTANCE PROGRAMS.**—Sections 3(a)(4), 1003(a)(3), 1403(a)(3), and 1603(a)(4) of the Social Security Act (as in effect without regard to section 301 of the Social Security Amendments of 1972) are each amended by redesignating subparagraph (B) as subparagraph (C) and inserting after subparagraph (A) the following new subparagraph:

42 USC 303,
1203, 1353, 1383
note.

42 USC
1381-1383c.

“(B) 100 percent of so much of such expenditures as are for the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus”.

(5) **UNDER THE FOOD STAMP PROGRAM.**—Section 16 of the Food Stamp Act of 1977 (7 U.S.C. 2025) is amended by adding at the end the following new subsection:

“(h) The Secretary is authorized to pay to each State agency an amount equal to 100 per centum of the costs incurred by the State agency in implementing and operating the immigration status verification system described in section 1137(d) of the Social Security Act.”.

State and local
governments.

42 USC 1320b-7.

(6) **UNDER HOUSING ASSISTANCE PROGRAMS.**—The United States Housing Act of 1937 (42 U.S.C. 1437 et seq.) is amended by adding at the end the following new section:

**“PAYMENT FOR IMPLEMENTATION OF IMMIGRATION STATUS
VERIFICATION SYSTEM**

“SEC. 20. The Secretary is authorized to pay to each public housing authority an amount equal to 100 percent of the costs incurred by the authority in implementing and operating the immigration status verification system under section 214(c) of the Housing and Community Development Act of 1980 with respect to financial assistance made available pursuant to this Act.”.

42 USC 1437r.

42 USC 1436a.

(7) **UNDER TITLE IV EDUCATIONAL ASSISTANCE.**—Section 489(a) of the Higher Education Act of 1965 (20 U.S.C. 1096) is amended by adding at the end the following: “In addition, the Secretary shall provide for payment to each institution of higher education an amount equal to 100 percent of the costs incurred by the institution in implementing and operating the immigration status verification system under section 484(c).”.

Ante, p. 1491.

20 USC 1091.
State and local
governments.
42 USC 1320b-7
note.

(c) EFFECTIVE DATES.—

(1) **IMMIGRATION AND NATURALIZATION SERVICE ESTABLISHING VERIFICATION SYSTEM BY OCTOBER 1, 1987.**—The Commissioner of Immigration and Naturalization shall implement a system for the verification of immigration status under paragraphs (3) and (4)(B)(i) of section 1137(d) of the Social Security Act (as amended by this section) so that the system is available to all the States by not later than October 1, 1987. Such system shall not be used by the Immigration and Naturalization Service for administrative (non-criminal) immigration enforcement purposes and shall be implemented in a manner that provides for verification of immigration status without regard to the sex, color, race, religion, or nationality of the individual involved.

42 USC 1320b-7.
Discrimination,
prohibition.

(2) **HIGHER MATCHING EFFECTIVE IN FISCAL YEAR 1988.**—The amendments made by subsection (b) take effect on October 1, 1987.

42 USC 502 note.

(3) **USE OF VERIFICATION SYSTEM REQUIRED IN FISCAL YEAR 1989.**—Except as provided in paragraph (4), the amendments made by subsection (a) take effect on October 1, 1988. States

Effective date.
42 USC 1320b-7
note.

have until that date to begin complying with the requirements imposed by those amendments.

42 USC 1320b-7
note.

(4) USE OF VERIFICATION SYSTEM NOT REQUIRED FOR A PROGRAM IN CERTAIN CASES.—

(A) REPORT TO RESPECTIVE CONGRESSIONAL COMMITTEES.—

With respect to each covered program (as defined in subparagraph (D)(i)), each appropriate Secretary shall examine and report to the appropriate Committees of the House of Representatives and of the Senate, by not later than April 1, 1988, concerning whether (and the extent to which)—

(i) the application of the amendments made by subsection (a) to the program is cost-effective and otherwise appropriate, and

(ii) there should be a waiver of the application of such amendments under subparagraph (B).

Effective date.

The amendments made by subsection (a) shall not apply with respect to a covered program described in subclause (II), (V), (VI), or (VII) of subparagraph (D)(i) until after the date of receipt of such report with respect to the program.

(B) WAIVER IN CERTAIN CASES.—If, with respect to a covered program, the appropriate Secretary determines, on the Secretary's own initiative or upon an application by an administering entity and based on such information as the Secretary deems persuasive (which may include the results of the report required under subsection (d)(1) and information contained in such an application), that—

(i) the appropriate Secretary or the administering entity has in effect an alternative system of immigration status verification which—

(I) is as effective and timely as the system otherwise required under the amendments made by subsection (a) with respect to the program, and

(II) provides for at least the hearing and appeals rights for beneficiaries that would be provided under the amendments made by subsection (a), or

(ii) the costs of administration of the system otherwise required under such amendments exceed the estimated savings,

such Secretary may waive the application of such amendments to the covered program to the extent (by State or other geographic area or otherwise) that such determinations apply.

(C) BASIS FOR DETERMINATION.—A determination under subparagraph (B)(ii) shall be based upon the appropriate Secretary's estimate of—

(i) the number of aliens claiming benefits under the covered program in relation to the total number of claimants seeking benefits under the program,

(ii) any savings in benefit expenditures reasonably expected to result from implementation of the verification program, and

(iii) the labor and nonlabor costs of administration of the verification system,

the degree to which the Immigration and Naturalization Service is capable of providing timely and accurate information to the administering entity in order to permit a

reliable determination of immigration status, and such other factors as such Secretary deems relevant.

(D) DEFINITIONS.—In this paragraph:

(i) The term “covered program” means each of the following programs:

(I) The aid to families with dependent children program under part A of title IV of the Social Security Act. Children and youth.
42 USC 601.

(II) The medicaid program under title XIX of the Social Security Act. Medicaid.
42 USC 1396.

(III) Any State program under a plan approved under title I, X, XIV, or XVI of the Social Security Act.

(IV) The unemployment compensation program under section 3304 of the Internal Revenue Code of 1954. 42 USC 301,
1201, 1351, 1381.

(V) The food stamp program under the Food Stamp Act of 1977. 26 USC 3304.

(VI) The programs of financial assistance for housing subject to section 214 of the Housing and Community Development Act of 1980. 7 USC 2026.

(VII) The program of grants, loans, and work assistance under title IV of the Higher Education Act of 1965. 42 USC 1436a.

Ante, p. 1308.

(ii) The term “appropriate Secretary” means, with respect to the covered program described in—

(I) subclauses (I) through (III) of clause (i), the Secretary of Health and Human Services;

(II) clause (i)(IV), the Secretary of Labor;

(III) clause (i)(V), the Secretary of Agriculture;

(IV) clause (i)(VI), the Secretary of Housing and Urban Development; and

(V) clause (i)(VII), the Secretary of Education.

(iii) The term “administering entity” means, with respect to the covered program described in—

(I) subclause (I), (II), (III), (IV), or (V) of clause (i), the State agency responsible for the administration of the program in a State;

(II) clause (i)(VI), the Secretary of Housing and Urban Development, a public housing agency, or another entity that determines the eligibility of an individual for financial assistance; and

(III) clause (i)(VII), an institution of higher education involved.

(5) FUNDS AUTHORIZED.—Such sums as may be necessary are authorized for the Immigration and Naturalization Service to carry out the purposes of this section.

(d) GAO REPORTS.—

42 USC 1320b-7
note.

(1) REPORT ON CURRENT PILOT PROJECTS.—The Comptroller General shall—

(A) examine current pilot projects relating to the System for Alien Verification of Eligibility (SAVE) operated by, or through cooperative agreements with, the Immigration and Naturalization Service, and Contracts.

(B) report, not later than October 1, 1987, to Congress and to the Commissioner of the Immigration and Naturalization Service concerning the effectiveness of such projects and

any problems with the implementation of such projects, particularly as they may apply to implementation of the system referred to in subsection (c)(1).

(2) REPORT ON IMPLEMENTATION OF VERIFICATION SYSTEM.—The Comptroller General shall—

(A) monitor and analyze the implementation of such system,

(B) report to Congress and to the appropriate Secretaries described in subsection (c)(4)(D)(ii), by not later than April 1, 1989, on such implementation, and

(C) include in such report such recommendations for changes in the system as may be appropriate.

TITLE II—LEGALIZATION

SEC. 201. LEGALIZATION OF STATUS.

(a) PROVIDING FOR LEGALIZATION PROGRAM.—(1) Chapter 5 of title II is amended by inserting after section 245 (8 U.S.C. 1255) the following new section:

“ADJUSTMENT OF STATUS OF CERTAIN ENTRANTS BEFORE JANUARY 1, 1982, TO THAT OF PERSON ADMITTED FOR LAWFUL RESIDENCE

8 USC 1255a.

“SEC. 245A. (a) TEMPORARY RESIDENT STATUS.—The Attorney General shall adjust the status of an alien to that of an alien lawfully admitted for temporary residence if the alien meets the following requirements:

“(1) TIMELY APPLICATION.—

“(A) DURING APPLICATION PERIOD.—Except as provided in subparagraph (B), the alien must apply for such adjustment during the 12-month period beginning on a date (not later than 180 days after the date of enactment of this section) designated by the Attorney General.

8 USC 1252.

“(B) APPLICATION WITHIN 30 DAYS OF SHOW-CAUSE ORDER.—An alien who, at any time during the first 11 months of the 12-month period described in subparagraph (A), is the subject of an order to show cause issued under section 242, must make application under this section not later than the end of the 30-day period beginning either on the first day of such 18-month period or on the date of the issuance of such order, whichever day is later.

8 USC 1154.

“(C) INFORMATION INCLUDED IN APPLICATION.—Each application under this subsection shall contain such information as the Attorney General may require, including information on living relatives of the applicant with respect to whom a petition for preference or other status may be filed by the applicant at any later date under section 204(a).

“(2) CONTINUOUS UNLAWFUL RESIDENCE SINCE 1982.—

“(A) IN GENERAL.—The alien must establish that he entered the United States before January 1, 1982, and that he has resided continuously in the United States in an unlawful status since such date and through the date the application is filed under this subsection.

“(B) NONIMMIGRANTS.—In the case of an alien who entered the United States as a nonimmigrant before January 1, 1982, the alien must establish that the alien's period of authorized stay as a nonimmigrant expired before such

ued under such section with respect to an alien without regard to the alien's adjustment of status under this section.

"(i) DISSEMINATION OF INFORMATION ON LEGALIZATION PROGRAM.—Beginning not later than the date designated by the Attorney General under subsection (a)(1)(A), the Attorney General, in cooperation with qualified designated entities, shall broadly disseminate information respecting the benefits which aliens may receive under this section and the requirements to obtain such benefits."

(2) The table of contents for chapter 5 of title II is amended by inserting after the item relating to section 245 the following new item:

"Sec. 245A. Adjustment of status of certain entrants before January 1, 1982, to that of person admitted for lawful residence."

(b) CONFORMING AMENDMENTS.—(1) Section 402 of the Social Security Act is amended by adding at the end thereof the following new subsection:

Children and youth.
42 USC 602.

"(f)(1) For temporary disqualification of certain newly legalized aliens from receiving aid to families with dependent children, see subsection (h) of section 245A of the Immigration and Nationality Act.

Ante, p. 3394.

"(2) In any case where an alien disqualified from receiving aid under such subsection (h) is the parent of a child who is not so disqualified and who (without any adjustment of status under such section 245A) is considered a dependent child under subsection (a)(33), or is the brother or sister of such a child, subsection (a)(38) shall not apply, and the needs of such alien shall not be taken into account in making the determination under subsection (a)(7) with respect to such child, but the income of such alien (if he or she is the parent of such child) shall be included in making such determination to the same extent that income of a stepparent is included under subsection (a)(31)."

(2)(A) Section 472(a) of such Act is amended by adding at the end thereof (after and below paragraph (4)) the following new sentence: "In any case where the child is an alien disqualified under section 245A(h) of the Immigration and Nationality Act from receiving aid under the State plan approved under section 402 in or for the month in which such agreement was entered into or court proceedings leading to the removal of the child from the home were instituted, such child shall be considered to satisfy the requirements of paragraph (4) (and the corresponding requirements of section 473(a)(1)(B)), with respect to that month, if he or she would have satisfied such requirements but for such disqualification."

42 USC 672.

(B) Section 473(a)(1) of such Act is amended by adding at the end thereof (after and below subparagraph (C)) the following new sentence:

42 USC 673.

"The last sentence of section 472(a) shall apply, for purposes of subparagraph (B), in any case where the child is an alien described in that sentence."

(c) MISCELLANEOUS PROVISIONS.—

8 USC 1255a note.

(1) PROCEDURES FOR PROPERTY ACQUISITION OR LEASING.—Notwithstanding the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 471 et seq.), the Attorney General is authorized to expend from the appropriation provided for the administration and enforcement of the Immigration and Nationality Act, such amounts as may be necessary for the leasing or acquisition of property in the fulfillment of this

8 USC 1101 note.

section. This authority shall end two years after the effective date of the legalization program.

(2) **USE OF RETIRED FEDERAL EMPLOYEES.**—Notwithstanding any other provision of law, the retired or retainer pay of a member or former member of the Armed Forces of the United States or the annuity of a retired employee of the Federal Government who retired on or before January 1, 1986, shall not be reduced while such individual is temporarily employed by the Immigration and Naturalization Service for a period of not to exceed 18 months to perform duties in connection with the adjustment of status of aliens under this section. The Service shall not temporarily employ more than 300 individuals under this paragraph. Notwithstanding any other provision of law, the annuity of a retired employee of the Federal Government shall not be increased or redetermined under chapter 83 or 84 of title 5, United States Code, as a result of a period of temporary employment under this paragraph.

5 USC 8301 *et seq.*; *ante*, p. 516.

8 USC 1255a note.

SEC. 202. CUBAN-HAITIAN ADJUSTMENT.

(a) **ADJUSTMENT OF STATUS.**—The status of any alien described in subsection (b) may be adjusted by the Attorney General, in the Attorney General's discretion and under such regulations as the Attorney General may prescribe, to that of an alien lawfully admitted for permanent residence if—

(1) the alien applies for such adjustment within two years after the date of the enactment of this Act;

(2) the alien is otherwise eligible to receive an immigrant visa and is otherwise admissible to the United States for permanent residence, except in determining such admissibility the grounds for exclusion specified in paragraphs (14), (15), (16), (17), (20), (21), (25), and (32) of section 212(a) of the Immigration and Nationality Act shall not apply;

(3) the alien is not an alien described in section 243(h)(2) of such Act;

(4) the alien is physically present in the United States on the date the application for such adjustment is filed; and

(5) the alien has continuously resided in the United States since January 1, 1982.

(b) **ALIENS ELIGIBLE FOR ADJUSTMENT OF STATUS.**—The benefits provided by subsection (a) shall apply to any alien—

(1) who has received an immigration designation as a Cuban/Haitian Entrant (Status Pending) as of the date of the enactment of this Act, or

(2) who is a national of Cuba or Haiti, who arrived in the United States before January 1, 1982, with respect to whom any record was established by the Immigration and Naturalization Service before January 1, 1982, and who (unless the alien filed an application for asylum with the Immigration and Naturalization Service before January 1, 1982) was not admitted to the United States as a nonimmigrant.

(c) **NO AFFECT ON FASCELL-STONE BENEFITS.**—An alien who, as of the date of the enactment of this Act, is a Cuban and Haitian entrant for the purpose of section 501 of Public Law 96-422 shall continue to be considered such an entrant for such purpose without regard to any adjustment of status effected under this section.

(d) **RECORD OF PERMANENT RESIDENCE AS OF JANUARY 1, 1982.**—Upon approval of an alien's application for adjustment of status

8 USC 1182.

8 USC 1253.

8 USC 1522 note.

Mexico and of other appropriate countries and advise the Attorney General regarding the operation of the alien temporary worker program established under section 216 of the Immigration and Nationality Act.

Ante, p. 3411.

(g) **CONFORMING AMENDMENT TO TABLE OF CONTENTS.**—The table of contents is amended by inserting after the item relating to section 215 the following new item:

“Sec. 216. Admission of temporary H-2A workers.”.

SEC. 302. LAWFUL RESIDENCE FOR CERTAIN SPECIAL AGRICULTURAL WORKERS.

(a) **IN GENERAL.**—(1) Chapter 1 of title II is amended by adding at the end the following new section:

“**SPECIAL AGRICULTURAL WORKERS**

“**SEC. 210. (a) LAWFUL RESIDENCE.**—

8 USC 1160.

“(1) **IN GENERAL.**—The Attorney General shall adjust the status of an alien to that of an alien lawfully admitted for temporary residence if the Attorney General determines that the alien meets the following requirements:

“(A) **APPLICATION PERIOD.**—The alien must apply for such adjustment during the 18-month period beginning on the first day of the seventh month that begins after the date of enactment of this section.

“(B) **PERFORMANCE OF SEASONAL AGRICULTURAL SERVICES AND RESIDENCE IN THE UNITED STATES.**—The alien must establish that he has—

“(i) resided in the United States, and

“(ii) performed seasonal agricultural services in the United States for at least 90 man-days, during the 12-month period ending on May 1, 1986. For purposes of the previous sentence, performance of seasonal agricultural services in the United States for more than one employer on any one day shall be counted as performance of services for only 1 man-day.

“(C) **ADMISSIBLE AS IMMIGRANT.**—The alien must establish that he is admissible to the United States as an immigrant, except as otherwise provided under subsection (c)(2).

“(2) **ADJUSTMENT TO PERMANENT RESIDENCE.**—The Attorney General shall adjust the status of any alien provided lawful temporary resident status under paragraph (1) to that of an alien lawfully admitted for permanent residence on the following date:

“(A) **GROUP 1.**—Subject to the numerical limitation established under subparagraph (C), in the case of an alien who has established, at the time of application for temporary residence under paragraph (1), that the alien performed seasonal agricultural services in the United States for at least 90 man-days during each of the 12-month periods ending on May 1, 1984, 1985, and 1986, the adjustment shall occur on the first day after the end of the one-year period that begins on the later of (I) the date the alien was granted such temporary resident status, or (II) the day after the last day of the application period described in paragraph (1)(A).

“(B) **GROUP 2.**—In the case of aliens to which subparagraph (A) does not apply, the adjustment shall occur on the

are directly contrary to clear and convincing facts contained in the record considered as a whole.

“(f) TEMPORARY DISQUALIFICATION OF NEWLY LEGALIZED ALIENS FROM RECEIVING AID TO FAMILIES WITH DEPENDENT CHILDREN.—During the five-year period beginning on the date an alien was granted lawful temporary resident status under subsection (a), and notwithstanding any other provision of law, the alien is not eligible for aid under a State plan approved under part A of title IV of the Social Security Act. Notwithstanding the previous sentence, in the case of an alien who would be eligible for aid under a State plan approved under part A of title IV of the Social Security Act but for the previous sentence, the provisions of paragraph (3) of section 245A(h) shall apply in the same manner as they apply with respect to paragraph (1) of such section and, for this purpose, any reference in section 245A(h)(3) to paragraph (1) is deemed a reference to the previous sentence.

“(g) TREATMENT OF SPECIAL AGRICULTURAL WORKERS.—For all purposes (subject to subsections (b)(3) and (f)) an alien whose status is adjusted under this section to that of an alien lawfully admitted for permanent residence, such status not having changed, shall be considered to be an alien lawfully admitted for permanent residence (within the meaning of section 101(a)(20)).

“(h) SEASONAL AGRICULTURAL SERVICES DEFINED.—In this section, the term ‘seasonal agricultural services’ means the performance of field work related to planting, cultural practices, cultivating, growing and harvesting of fruits and vegetables of every kind and other perishable commodities, as defined in regulations by the Secretary of Agriculture.”

(2) The table of contents is amended by inserting after the item relating to section 209 the following new item:

“Sec. 210. Special agricultural workers.”

(b) CONFORMING AMENDMENTS.—(1) Section 402(f) of the Social Security Act (as added by section 201(b)(1) of this Act) is amended—

(A) by inserting “and subsection (f) of section 210 of such Act” before the period at the end of paragraph (1);

(B) by inserting “or (f)” after “such subsection (h)” in paragraph (2); and

(C) by inserting “or 210” after “such section 245A” in paragraph (2).

(2) The last sentence of section 472(a) of such Act (as added by section 201(b)(2)(A) of this Act) is amended by inserting “or 210(f)” after “245A(h)”.

SEC. 303. DETERMINATIONS OF AGRICULTURAL LABOR SHORTAGES AND ADMISSION OF ADDITIONAL SPECIAL AGRICULTURAL WORKERS.

(a) IN GENERAL.—Chapter 1 of title II is amended by adding after section 210 (added by section 302 of this title) the following new section:

“DETERMINATION OF AGRICULTURAL LABOR SHORTAGES AND ADMISSION OF ADDITIONAL SPECIAL AGRICULTURAL WORKERS

“SEC. 210A. (a) DETERMINATION OF NEED TO ADMIT ADDITIONAL SPECIAL AGRICULTURAL WORKERS.—

“(1) IN GENERAL.—Before the beginning of each fiscal year (beginning with fiscal year 1990 and ending with fiscal year 1993), the Secretaries of Labor and Agriculture (in this section referred to as the ‘Secretaries’) shall jointly determine the number (if any) of additional aliens who should be admitted to

“(4) The term ‘man-day’ means, with respect to seasonal agricultural services, the performance during a calendar day of at least 4 hours of seasonal agricultural services.”.

(b) DEPORTATION OF CERTAIN WORKERS WHO FAIL TO PERFORM SEASONAL AGRICULTURAL SERVICES.—Section 241(a) (8 U.S.C. 1251(a)) is amended—

(1) by striking out “or” at the end of paragraph (18),

(2) by striking out the period at the end of paragraph (19) and inserting in lieu thereof “; or”, and

(3) by adding at the end the following new paragraph:

“(20) obtains the status of an alien who becomes lawfully admitted for temporary residence under section 210A and fails to meet the requirement of section 210A(d)(5)(A) by the end of the applicable period.”.

Ante, p. 3422.

(c) APPLICATION OF CERTAIN STATE ASSISTANCE PROVISIONS.—For purposes of section 204 of this Act (relating to State legalization assistance), the term “eligible legalized alien” includes an alien who becomes an alien lawfully admitted for permanent or temporary residence under section 210 or 210A of the Immigration and Nationality Act, but only until the end of the 5-year period beginning on the date the alien was first granted permanent or temporary resident status.

8 USC 1255a note.

Ante, pp. 3417, 3422.

(d) CLERICAL AMENDMENT.—The table of contents is amended by inserting after the item relating to section 210 (as inserted by section 302) the following new item:

“Sec. 210A. Determination of agricultural labor shortages and admission of additional special agricultural workers.”.

(e) CONFORMING AMENDMENTS.—(1) Section 402(f) of the Social Security Act (as added by section 201(b)(1) of this Act and amended by section 302(b)(1) of this Act) is further amended—

42 USC 602.

(A) by striking out “and subsection (f) of section 210 of such Act” in paragraph (1) and inserting in lieu thereof “, subsection (f) of section 210 of such Act, and subsection (d)(7) of section 210A of such Act”;

(B) by striking out “such subsection (h) or (f)” in paragraph (2) and inserting in lieu thereof “such subsection (h), (f), or (d)(7)”; and

(C) by striking out “such section 245A or 210” in paragraph (2) and inserting in lieu thereof “such section 245A, 210, or 210A”.

(2) The last sentence of section 472(a) of such Act (as added by section 201(b)(2)(A) of this Act and amended by section 302(b)(2) of this Act) is further amended by striking out “245A(h) or 210(f)” and inserting in lieu thereof “245A(h), 210(f), or 210A(d)(7)”.

42 USC 672.

SEC. 304. COMMISSION ON AGRICULTURAL WORKERS.

(a) ESTABLISHMENT AND COMPOSITION OF COMMISSION.—(1) There is established a Commission on Agricultural Workers (hereinafter in this section referred to as the “Commission”), to be composed of 12 members—

8 USC 1160 note.

(A) six to be appointed by the President,

(B) three to be appointed by the Speaker of the House of Representatives, and

(C) three to be appointed by the President pro tempore of the Senate.

(2) In making appointments under paragraph (1)(A), the President shall consult—

(A) with the Attorney General in appointing two members,

(2) Seven members of the Commission shall constitute a quorum, but a lesser number may hold hearings.

(e) **TERMINATION DATE.**—The Commission shall terminate on the date on which a report is required to be transmitted by subsection (c), except that the Commission may continue to function for not more than thirty days thereafter for the purpose of concluding its activities.

TITLE VII—FEDERAL RESPONSIBILITY FOR DEPORTABLE AND EXCLUDABLE ALIENS CONVICTED OF CRIMES

SEC. 701. EXPEDITIOUS DEPORTATION OF CONVICTED ALIENS.

Section 242 (8 U.S.C. 1254) is amended by adding at the end the following new subsection: 8 USC 1252.

“(i) In the case of an alien who is convicted of an offense which makes the alien subject to deportation, the Attorney General shall begin any deportation proceeding as expeditiously as possible after the date of the conviction.”.

SEC. 702. IDENTIFICATION OF FACILITIES TO INCARCERATE DEPORTABLE OR EXCLUDABLE ALIENS.

The President shall require the Secretary of Defense, in cooperation with the Attorney General and by not later than 60 days after the date of the enactment of this Act, to provide to the Attorney General a list of facilities of the Department of Defense that could be made available to the Bureau of Prisons for use in incarcerating aliens who are subject to exclusion or deportation from the United States.

President of U.S

Approved November 6, 1986.

LEGISLATIVE HISTORY—S. 1200 (H.R. 3810):

HOUSE REPORTS: No. 99-682, Pt. 1 (Comm. on the Judiciary), Pt. 2 (Comm. on Education and Labor), Pt. 3 (Comm. on Ways and Means), Pt. 4 (Comm. on Energy and Commerce), and Pt. 5 (Comm. on Agriculture), all accompanying H.R. 3810.

SENATE REPORTS: No. 99-132 (Comm. on the Judiciary) and No. 99-1000 (Comm. of Conference).

CONGRESSIONAL RECORD:

Vol. 131 (1985): Sept. 11-13, 16-19, considered and passed Senate.

Vol. 132 (1986): Oct. 9, H.R. 3810 considered and passed House; proceedings vacated and S. 1200, amended, passed in lieu.

Oct. 15, House agreed to conference report.

Oct. 17, Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 22 (1986):

Nov. 6, Presidential statement and remarks.

IMMIGRATION CONTROL AND LEGALIZATION AMENDMENTS ACT OF 1986

JULY 16, 1986.—Ordered to be printed

Mr. MAZZOLI, from the Committee on the Judiciary,
submitted the following

REPORT

together with

ADDITIONAL AND DISSENTING VIEWS

[To accompany H.R. 3810]

[Including cost estimate of the Congressional Budget Office]

The Committee on the Judiciary, to whom was referred the bill (H.R. 3810) having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; REFERENCES IN ACT.

(a) **SHORT TITLE.**—This Act may be cited as the “Immigration Control and Legalization Amendments Act of 1986”.

(b) **AMENDMENTS TO IMMIGRATION AND NATIONALITY ACT.**—Except as otherwise specifically provided in this Act, whenever in this Act an amendment or repeal is expressed as an amendment to, or repeal of, a provision, the reference shall be deemed to be made to the Immigration and Nationality Act.

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Sec. 1. Short title; references in Act.

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- Sec. 112. Unlawful transportation of aliens to the United States.
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 Sec. 202. Cuban-Haitian adjustment.
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Part A—Temporary Agricultural Workers

- Sec. 301. H-2A agricultural workers.
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- Sec. 311. Change in colonial quota.
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TITLE IV—REPORTS TO CONGRESS

- Sec. 401. Triennial reports concerning immigration.
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 Sec. 403. Reports on H-2A program.
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TITLE V—STATE AND LOCAL ASSISTANCE FOR INCARCERATION COSTS OF ILLEGAL ALIENS AND CERTAIN CUBAN NATIONALS

- Sec. 501. Reimbursement of States and localities for costs of incarcerating illegal aliens and certain Cuban nationals.

TITLE I—CONTROL OF ILLEGAL IMMIGRATION

PART A—EMPLOYMENT

SEC. 101. CONTROL OF UNLAWFUL EMPLOYMENT OF ALIENS AND UNFAIR IMMIGRATION-RELATED EMPLOYMENT PRACTICES.

- (a) IN GENERAL.—(1) Chapter 8 of title II is amended by inserting after section 274 (8 U.S.C. 1324) the following new section:

“UNLAWFUL EMPLOYMENT OF ALIENS

“SEC. 274A. (a) MAKING EMPLOYMENT OF UNAUTHORIZED ALIENS UNLAWFUL.—

“(1) IN GENERAL.—It is unlawful for a person or other entity after the date of the enactment of this section to hire, or to recruit or refer for a fee, for employment in the United States—

“(A) an alien knowing the alien is an unauthorized alien (as defined in subsection (g)) with respect to such employment, or

“(B) an individual without complying with the requirements of subsection (b).

“(2) CONTINUING EMPLOYMENT.—It is unlawful for a person or other entity, after hiring an alien for employment subsequent to the date of the enactment of this section and in accordance with paragraph (1), to continue to employ the alien in the United States knowing the alien is (or has become) an unauthorized alien with respect to such employment.

“(3) DEFENSE.—A person or entity that establishes that it has complied in good faith with the requirements of subsection (b) with respect to the hiring, recruiting, or referral for employment of an alien in the United States has established an affirmative defense that the person or entity has not violated paragraph (1)(A) with respect to such hiring, recruiting, or referral.

“(4) USE OF LABOR THROUGH CONTRACT.—For purposes of this section, a person or other entity who uses a contract, subcontract, or exchange, entered into, renegotiated, or extended after the date of the enactment of this section, to obtain the labor of an alien in the United States knowing that the alien is an unau-

thorized alien (as defined in subsection (g)) with respect to performing such labor, shall be considered to have hired the alien for employment in the United States in violation of paragraph (1)(A).

"(5) USE OF STATE EMPLOYMENT AGENCY DOCUMENTATION.—For purposes of paragraphs (1)(B) and (3), a person or entity shall be deemed to have complied with the requirements of subsection (b) with respect to the hiring of an individual who was referred for such employment by a State employment agency (as defined by the Attorney General), if the person or entity has and retains (for the period and in the manner described in subsection (b)(3)) appropriate documentation of such referral by that agency, which documentation certifies that the agency has complied with the procedures specified in subsection (b) with respect to the individual's referral.

"(b) EMPLOYMENT VERIFICATION SYSTEM.—The requirements referred to in paragraphs (1)(B) and (3) of subsection (a) are, in the case of a person or other entity hiring, recruiting, or referring an individual for employment in the United States, the requirements specified in the following three paragraphs (and, to the extent applicable, paragraph (7)(C)):

"(1) ATTESTATION AFTER EXAMINATION OF DOCUMENTATION AND VALIDATION OF SOCIAL SECURITY ACCOUNT NUMBER.—

"(A) IN GENERAL.—The person or entity must attest, under penalty of perjury and on a form established or designated by the Attorney General by regulation, that he has verified that the individual is eligible to be employed (or recruited or referred for employment) in the United States—

"(i) by examining—

"(I) the individual's United States passport, or the individual's unexpired foreign passport, if the foreign passport has an appropriate, unexpired endorsement of the Attorney General authorizing the individual's employment in the United States, or

"(II) a document described in subparagraph (B) and a document described in subparagraph (C); and

"(ii) by validating (to the extent and in the manner required under paragraph (7)(C)) the social security account number presented by the individual.

A person or entity has complied with the requirement of clause (i) of this subparagraph with respect to examination of a document if the document reasonably appears on its face to be genuine. If an individual provides a document or combination of documents that reasonably appears on its face to be genuine and that is sufficient to meet the requirements of clause (i), nothing in this paragraph shall be construed as requiring the person or entity to solicit the production of any other document or as requiring the individual to produce such a document.

"(B) DOCUMENTS EVIDENCING EMPLOYMENT AUTHORIZATION.—A document described in this subparagraph is the individual's—

"(i) social security account number card issued by the Social Security Administration,

"(ii) certificate of birth in the United States or United States consular report of birth, or

"(iii) in the case of an individual without a social security card or a certificate of birth in the United States or a United States consular report of birth, any other identification acceptable to the Attorney General.

"(C) DOCUMENTS ESTABLISHING IDENTITY OF INDIVIDUAL.—A document described in this subparagraph is the individual's—

"(i) alien documentation, identification, and telecommunication card, or similar fraud-resistant card issued by the Attorney General to aliens, or other identification issued by the Attorney General to aliens who establish eligibility for employment,

"(ii) driver's license or similar document issued for the purpose of identification by a State, if it contains a photograph of the individual or such other personal identifying information relating to the individual as the Attorney General finds, by regulation, sufficient for purposes of this section, or

"(iii) in the case of individuals under 16 years of age or in a State which does not provide for issuance of an identification document (other than a driver's license) referred to in clause (ii), documentation of personal identity of such other type as the Attorney General finds, by regulation, provides a reliable means of identification.

"(2) **INDIVIDUAL ATTESTATION OF EMPLOYMENT AUTHORIZATION.**—The individual must attest, under penalty of perjury and on the form designated or established by the Attorney General for purposes of paragraph (1), that the individual is a citizen or national of the United States, an alien lawfully admitted for permanent residence, or an alien who is authorized under this Act or by the Attorney General to be hired, recruited, or referred for such employment.

"(3) **RETENTION OF VERIFICATION FORM.**—After completion of such form in accordance with paragraphs (1) and (2), the person or entity must retain the form and make it available for inspection by officers of the Service or of the Department of Labor during such period as the Attorney General shall specify in regulations.

"(4) **COPYING OF DOCUMENTATION PERMITTED.**—Notwithstanding any other provision of law, the person or entity may copy a document presented by an individual pursuant to this subsection and may retain the copy, but only (except as otherwise permitted under law) for the purpose of complying with the requirements of this subsection.

"(5) **TIME FOR COMPLIANCE.**—A person or entity has complied with the requirements of this subsection, with respect to the hiring of an individual, if the requirements of this subsection are first met not later than noon of the day following the day on which the individual is first employed by that person or entity.

"(6) **LIMITATION ON USE OF ATTESTATION FORM.**—A form designated or established by the Attorney General under this subsection and any information contained in or appended to such form, may not be used for purposes other than for enforcement of this section or section 1546 of title 18, United States Code.

"(7) **SOCIAL SECURITY ACCOUNT NUMBER VALIDATION SYSTEM.**—

"(A) **ESTABLISHMENT OF SYSTEM.**—The Attorney General, in cooperation with the Secretaries of Labor and Health and Human Services, shall establish a method to validate the social security account numbers of individuals applying to be hired, or recruited or referred for a fee, for employment in the United States.

"(B) **PUBLICATION.**—The Attorney General shall provide for publication in the Federal Register of notice of the establishment of the validation method and the procedures for its use not earlier than 6 months, and not later than 18 months, after the date of the enactment of this section.

"(C) **IMPLEMENTATION.**—Beginning on an effective date (not earlier than 90 days, and not later than 180 days, after the date final regulations are published under subparagraph (B)) set forth by the Attorney General, in order to comply with the requirement of paragraph (1)(A) of this subsection in the case of a person or other entity hiring, or recruiting or referring for a fee, an individual for employment in the United States, the person or other entity must, pursuant to the verification method—

"(i) submit the social security account number of the individual, and

"(ii) be provided and record on the form designated or established for purposes of that paragraph a validation code indicating that the number submitted is valid.

"(c) **NO AUTHORIZATION OF NATIONAL IDENTIFICATION CARDS.**—Nothing in this section shall be construed to authorize, directly or indirectly, the issuance or use of national identification cards or the establishment of a national identification card.

"(d) **PENALTIES.**—

"(1) **CIVIL MONEY PENALTY FOR UNLAWFUL EMPLOYMENT, RECRUITING, OR REFERRAL.**—

"(A) **IN GENERAL.**—In the case of a person or entity which is determined (after notice and opportunity for an administrative hearing under paragraph (4)(A)) to have violated paragraph (1)(A) or (2) of subsection (a) and which—

"(i) has not previously been determined (after opportunity for a hearing under paragraph (4)(A)) to have violated either such paragraph, the person or entity shall be subject to a civil penalty of not less than \$1000, and not more than \$2,000, for each unauthorized alien with respect to whom the violation occurred, or

"(ii) has previously been determined (after opportunity for a hearing under paragraph (4)(A)) to have violated either such paragraph, the person or entity shall be subject to a civil penalty of not less than \$2,000, and not more than \$5,000, for each unauthorized alien with respect to whom the violation occurred.

“(i) APPLICATION OF CERTAIN NLRB PROCEDURES.—

“(1) IN GENERAL.—The provisions of subsections (d), (e), (f), (g), and (j) of section 10 of the National Labor Relations Act (29 U.S.C. 160) shall apply to court petitions and review of orders under this section in the same manner as they apply to court petitions and orders under that section, except that—

“(A) the authority of the General Counsel or the National Labor Relations Board under subsections (d), (f), and (g) and the second through seventh sentences of subsection (e) shall be exercised for purposes of this paragraph through the Special Counsel or the administrative law judge involved, respectively, and

“(B) the authority of the National Labor Relations Board under subsection (j) and the first sentence of subsection (e) shall be exercised for purposes of this paragraph through the Special Counsel.

“(2) AWARDING OF ATTORNEYS’ FEES.—In any proceeding referred to in paragraph (1), the court, in its discretion, may allow a prevailing party, other than the United States, a reasonable attorney’s fee as part of costs.”.

(c) CONFORMING AMENDMENTS TO MIGRANT AND SEASONAL AGRICULTURAL WORKER PROTECTION ACT.—(1) The Migrant and Seasonal Agricultural Worker Protection Act (Public Law 97-470) is amended—

(A) by striking out “101(a)(15)(H)(ii)” in paragraphs (8)(B) and (10)(B) of section 3 (29 U.S.C. 1802) and inserting in lieu thereof “101(a)(15)(H)(ii)(a)”;

(B) in section 103(a) (29 U.S.C. 1813(a))—

(i) by striking out “or” at the end of paragraph (4),

(ii) by striking out the period at the end of paragraph (5) and inserting in lieu thereof “; or”, and

(iii) by adding at the end the following new paragraph:

“(6) has been found to have violated paragraph (1) or (2) of section 274A(a) of the Immigration and Nationality Act.”;

(C) by striking out section 106 (29 U.S.C. 1816) and the corresponding item in the table of contents; and

(D) by striking out “section 106” in section 501(b) (29 U.S.C. 1851(b)) and by inserting in lieu thereof “paragraph (1) or (2) of section 274A(a) of the Immigration and Nationality Act”.

(2) The amendments made by paragraph (1) shall apply to the employment, recruitment, referral, or utilization of the services of an individual occurring on or after the first day of the seventh month beginning after the date of the enactment of this Act.

(d) NO EFFECT ON EEOC AUTHORITY.—Except as may be specifically provided in this section, nothing in this section shall be construed to restrict the authority of the Equal Employment Opportunity Commission to investigate allegations, in writing and under oath or affirmation, of unlawful employment practices, as provided in section 706 of the Civil Rights Act of 1964 (42 U.S.C. 2000e-5), or any other authority provided therein.

(e) CONFORMING AMENDMENT TO TABLE OF CONTENTS.—The table of contents is amended by inserting after the item relating to section 274 the following new items:

“Sec. 274A. Unlawful employment of aliens.

“Sec. 274B. Unfair immigration-related employment practices.”.

SEC. 102. FRAUD AND MISUSE OF CERTAIN IMMIGRATION-RELATED DOCUMENTS.

(a) APPLICATION TO ADDITIONAL DOCUMENTS.—Section 1546 of title 18, United States Code, is amended—

(1) by amending the heading to read as follows:

“§ 1546. Fraud and misuse of visas, permits, and other documents”;

(2) by striking out “or other document required for entry into the United States” in the first paragraph and inserting in lieu thereof “border crossing card, alien registration receipt card, or other document prescribed by statute or regulation for entry into or as evidence of authorized stay or employment in the United States”;

(3) by striking out “or document” in the first paragraph and inserting in lieu thereof “border crossing card, alien registration receipt card, or other document prescribed by statute or regulation for entry into or as evidence of authorized stay or employment in the United States”;

(4) by striking out “\$2,000” and inserting in lieu thereof “\$5,000”;

(5) by inserting “(a)” before “Whoever” the first place it appears; and

(6) by adding at the end the following new subsections:

“(b) Whoever uses—

"(1) an identification document, knowing (or having reason to know) that the document was not issued lawfully for the use of the possessor,

"(2) an identification document knowing (or having reason to know) that the document is false, or

"(3) a false attestation,

for the purpose of satisfying a requirement of section 274A(b) of the Immigration and Nationality Act, shall be fined not more than \$5,000, or imprisoned not more than two years, or both.

"(c) This section does not prohibit any lawfully authorized investigative, protective, or intelligence activity of a law enforcement agency of the United States, a State, or a subdivision of a State, or of an intelligence agency of the United States, or any activity authorized under title V of the Organized Crime Control Act of 1970 (18 U.S.C. note prec. 3481)."

(b) CONFORMING AMENDMENT TO TABLE OF SECTIONS.—The item relating to section 1546 in the table of sections of chapter 75 of such title is amended to read as follows:

"1546. Fraud and misuse of visas, permits, and other documents."

PART B—IMPROVEMENT OF ENFORCEMENT AND SERVICES

SEC. 111. AUTHORIZATION OF APPROPRIATIONS FOR ENFORCEMENT AND SERVICE ACTIVITIES OF THE IMMIGRATION AND NATURALIZATION SERVICE.

(a) TWO ESSENTIAL ELEMENTS.—Two essential elements of the program of immigration control and reform established by this Act are—

(1) an increase in the border patrol and other enforcement activities of the Immigration and Naturalization Service and of other appropriate Federal agencies in order to prevent and deter the illegal entry of aliens into the United States, and

(2) an increase in examinations and other service activities of the Immigration and Naturalization Service and other appropriate Federal agencies in order to ensure prompt and efficient adjudication of petitions and applications provided for under the Immigration and Nationality Act.

(b) INCREASED AUTHORIZATION OF APPROPRIATIONS FOR INS AND EOIR.—In addition to any other amounts authorized to be appropriated, in order to carry out this Act there are authorized to be appropriated to the Department of Justice—

(1) for the Immigration and Naturalization Service, for fiscal year 1986, \$422,000,000, and for fiscal year 1987, \$419,000,000; and

(2) for the Executive Office of Immigration Review, for fiscal year 1986, \$12,000,000, and for fiscal year 1987, \$15,000,000.

(c) USE OF FUNDS FOR IMPROVED SERVICES.—Of the funds appropriated to the Department of Justice for the Immigration and Naturalization Service, the Attorney General shall provide for improved immigration and naturalization services and for enhanced community outreach and in-service training of personnel of the Service.

(d) DATA PROCESSING REQUIREMENTS OF THE INS.—(1) The Attorney General shall report to the Committees on the Judiciary of the House of Representatives and the Senate, and to any other appropriate committees of the Congress, not later than six months after the date of the enactment of this Act, on the results of a comprehensive analysis of the data processing requirements of the Immigration and Naturalization Service. The report shall include—

(A) an assessment of the data processing needs of the Service, and

(B) an analysis of the alternatives considered to meet those requirements, including the use of regional centers and other available resources of the Department of Justice.

(2) The Attorney General shall provide that any automatic data processing equipment, facilities, and software of the Immigration and Naturalization Service are acquired consistent with the provisions of section 111 of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 759). No such equipment, facilities, or software may be ordered, acquired, or installed without the prior review and approval of the Administrator of General Services. The Administrator shall notify Congress in writing of all such approvals, together with any limitations or conditions thereon, or modifications thereto.

(3) Effective November 18, 1985, neither the Attorney General nor the Immigration and Naturalization Service may order, acquire, or install any new data processing equipment, facilities, or software for the use of the Service under the existing contract known as Acquisition II until 45 days after the date that Congress receives written notification under paragraph (2) of the approval, by the Administrator of General Services, of the order, acquisition, or installation.

SEC. 112. UNLAWFUL TRANSPORTATION OF ALIENS TO THE UNITED STATES.

Subsection (a) of section 274 (8 U.S.C. 1324) is amended to read as follows:

“(a) CRIMINAL PENALTIES.—(1) Any person who—

“(A) knowing that a person is an alien, brings to or attempts to bring to the United States in any manner whatsoever such person at a place other than a designated port of entry or place other than as designated by the Commissioner, regardless of whether such alien has received prior official authorization to come to, enter, or reside in the United States and regardless of any future official action which may be taken with respect to such alien;

“(B) knowing or in reckless disregard of the fact that an alien has come to, entered, or remains in the United States in violation of law, transports, or moves or attempts to transport or move such alien within the United States by means of transportation or otherwise, in furtherance of such violation of law; or

“(C) knowing or in reckless disregard of the fact that an alien has come to, entered, or remains in the United States in violation of law, conceals, harbors, or shields from detection, or attempts to conceal, harbor, or shield from detection, such alien in any place, including any building or any means of transportation,

shall be fined not more than \$10,000, imprisoned not more than five years, or both, for each alien in respect to whom any violation of this paragraph occurs.

“(2) Any person who, knowing or in reckless disregard of the fact that an alien has not received prior official authorization to come to, enter, or reside in the United States, brings to or attempts to bring to the United States in any manner whatsoever, such alien, regardless of any official action which may later be taken with respect to such alien shall, for each transaction constituting a violation of this paragraph, regardless of the number of aliens involved—

“(A) be fined not more than \$5,000, or imprisoned not more than one year, or both; or

“(B) in the case of—

“(i) a second or subsequent offense,

“(ii) an offense done for the purpose of commercial advantage or private financial gain, or

“(iii) an offense in which the alien is not upon arrival immediately brought and presented to an appropriate immigration officer at a designated port of entry,

be fined not more than \$10,000, or imprisoned not more than five years, or both.”.

SEC. 113. TREATMENT OF IMMIGRATION EMERGENCIES.

(a) IMMIGRATION CONTINGENCY PLAN.—Section 103 (8 U.S.C. 1103) is amended by adding at the end the following new subsection:

“(c) The Attorney General shall develop, and may from time to time modify, a contingency plan to provide for the allocation and management of personnel and resources in the event of an immigration emergency. In developing such a plan, the Attorney General shall consult with the Judiciary Committees of the House of Representatives and of the Senate and with State and local governments.”.

(b) IMMIGRATION EMERGENCY FUND.—Section 404 (8 U.S.C. 1101 note) is amended by inserting “(a)” after “SEC. 404.” and by adding at the end the following new subsection:

“(b) There are authorized to be appropriated to an immigration emergency fund, to be established in the Treasury, \$35,000,000, to be used in accordance with the immigration contingency plan developed under section 103(c) to provide for an increase in border patrol or other enforcement activities of the Service and for reimbursement of State and localities in providing assistance as requested by the Attorney General in meeting an immigration emergency, except that no amounts may be withdrawn from such funds with respect to an emergency unless the President has determined that the immigration emergency exists and has certified such fact to the Judiciary Committees of the House of Representatives and of the Senate.”.

PART C—VERIFICATION OF STATUS UNDER CERTAIN PROGRAMS

SEC. 121. VERIFICATION OF IMMIGRATION STATUS OF ALIENS APPLYING FOR BENEFITS UNDER CERTAIN PROGRAMS.

(a) REQUIRING IMMIGRATION STATUS VERIFICATION.—

(1) UNDER AFDC, MEDICAID, UNEMPLOYMENT COMPENSATION, AND FOOD STAMP PROGRAMS.—Section 1137 of the Social Security Act (42 U.S.C. 1320b-7) is amended—

(A) in the matter in subsection (a) before paragraph (1), by inserting "which meets the requirements of subsection (d) and" after "income and eligibility verification system",

(B) in subsection (b), by striking out "income verification system" in the matter preceding paragraph (1) and inserting in lieu thereof "income and eligibility verification system", and

(C) by adding at the end the following new subsections:

"(d) The requirements of this subsection, with respect to an income and eligibility verification system of a State, are as follows:

"(1)(A) The State shall require, as a condition of an individual's eligibility for benefits under any program listed in subsection (b), a declaration in writing by the individual (or, in the case of an individual who is a child, by another on the individual's behalf), under penalty of perjury, stating whether or not the individual is a citizen or national of the United States, and, if that individual is not a citizen or national of the United States, that the individual is in a satisfactory immigration status.

"(B) In this subsection—

"(i) in the case of the program described in subsection (b)(1), any reference to an individual's eligibility for benefits under the program shall be considered a reference to the individual's being considered a dependent child or to the individual's being treated as a caretaker relative or other person whose needs are to be taken into account in making the determination under section 402(a)(7),

"(ii) in the case of the program described in subsection (b)(4)—

"(I) any reference to the State shall be considered a reference to the State agency, and

"(II) any reference to an individual's eligibility for benefits under the program shall be considered a reference to the individual's eligibility to participate in the program as a member of a household, and

"(III) the term 'satisfactory immigration status' means an immigration status which does not make the individual ineligible for benefits under the applicable program.

"(2) If such an individual is not a citizen or national of the United States, there must be presented either—

"(A) alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual's alien admission number or alien file number (or numbers if the individual has more than one number), or

"(B) such other documents as the State determines constitutes reasonable evidence indicating a satisfactory immigration status.

"(3) If the documentation described in paragraph (2)(A) is presented, the State shall utilize the individual's alien file or alien admission number to verify with the Immigration and Naturalization Service the individual's immigration status through an automated or other system (designated by the Service for use with States) that—

"(A) utilizes the individual's name, file number, admission number, or other means permitting efficient verification, and

"(B) protects the individual's privacy to the maximum degree possible.

"(4) In the case of such an individual who is not a citizen or national of the United States, if, at the time of application for benefits, the statement described in paragraph (1) is submitted but the documentation required under paragraph (2) is not presented or if the documentation required under paragraph (2)(A) is presented but such documentation is not verified under paragraph (3)—

"(A) the State—

"(i) shall provide a reasonable opportunity to submit to the State evidence indicating a satisfactory immigration status, and

"(ii) may not delay, deny, reduce, or terminate the individual's eligibility for benefits under the program on the basis of the individual's immigration status until such a reasonable opportunity has been provided; and

"(B) if there are submitted documents which the State determines constitutes reasonable evidence indicating such status—

"(i) the State shall transmit to the Immigration and Naturalization Service photostatic or other similar copies of such documents for official verification,

“(ii) pending such verification, the State may not delay, deny, reduce, or terminate the individual’s eligibility for benefits under the program on the basis of the individual’s immigration status, and

“(iii) the State shall not be liable for the consequences of any action, delay, or failure of the Service to conduct such verification.

“(5) If the State determines, after complying with the requirements of paragraph (4), that such an individual is not in a satisfactory immigration status under the applicable program—

“(A) the State shall deny or terminate the individual’s eligibility for benefits under the program, and

“(B) the applicable fair hearing process shall be made available with respect to the individual.

“(e) Each Federal agency responsible for administration of a program described in subsection (b) shall not take any compliance, disallowance, penalty, or other regulatory action against a State with respect to any error in the State’s determination to make an individual eligible for benefits based on citizenship or immigration status—

“(1) if the State has provided such eligibility based on a verification of satisfactory immigration status by the Immigration and Naturalization Service,

“(2) because the State, under subsection (d)(4)(A)(ii), was required to provide a reasonable opportunity to submit documentation,

“(3) because the State, under subsection (d)(4)(B)(ii), was required to wait for the response of the Immigration and Naturalization Service to the State’s request for official verification of the immigration status of the individual, or

“(4) because of a fair hearing process described in subsection (d)(5)(B).”

(2) UNDER SSI PROGRAM.—Section 1631(e)(1)(B) of such Act (42 U.S.C. 1383(e)(1)(B)) is amended by striking out “and (c) of such section 1137” and inserting in lieu thereof “, (c), and (d) of such section 1137”.

(3) UNDER HOUSING ASSISTANCE PROGRAMS.—Section 214 of the Housing and Community Development Act of 1980 (42 U.S.C. 1436a) is amended by adding at the end the following new subsections:

“(d) The following conditions apply with respect to financial assistance being provided for the benefit of an individual:

“(1)(A) There must be a declaration in writing by the individual (or, in the case of an individual who is a child, by another on the individual’s behalf), under penalty of perjury, stating whether or not the individual is a citizen or national of the United States, and, if that individual is not a citizen or national of the United States, that the individual is in a satisfactory immigration status.

“(B) In this subsection, the term ‘satisfactory immigration status’ means an immigration status which does not make the individual ineligible for financial assistance.

“(2) If such an individual is not a citizen or national of the United States, there must be presented either—

“(A) alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual’s alien admission number or alien file number (or numbers if the individual has more than one number), or

“(B) such other documents as the Secretary determines constitutes reasonable evidence indicating a satisfactory immigration status.

“(3) If the documentation described in paragraph (2)(A) is presented, the Secretary shall utilize the individual’s alien file or alien admission number to verify with the Immigration and Naturalization Service the individual’s immigration status through an automated or other system (designated by the Service for use with States) that—

“(A) utilizes the individual’s name, file number, admission number, or other means permitting efficient verification, and

“(B) protects the individual’s privacy to the maximum degree possible.

“(4) In the case of such an individual who is not a citizen or national of the United States, if, at the time of application for financial assistance, the statement described in paragraph (1) is submitted but the documentation required under paragraph (2) is not presented or if the documentation required under paragraph (2)(A) is presented but such documentation is not verified under paragraph (3)—

“(A) the Secretary—

“(i) shall provide a reasonable opportunity to submit to the Secretary evidence indicating a satisfactory immigration status, and

"(ii) may not delay, deny, reduce, or terminate the individual's eligibility for financial assistance on the basis of the individual's immigration status until such a reasonable opportunity has been provided; and
 "(B) if there are submitted documents which the Secretary determines constitutes reasonable evidence indicating such status—

"(i) the Secretary shall transmit to the Immigration and Naturalization Service photostatic or other similar copies of such documents for official verification,

"(ii) pending such verification, the Secretary may not delay, deny, reduce, or terminate the individual's eligibility for financial assistance on the basis of the individual's immigration status, and

"(iii) the Secretary shall not be liable for the consequences of any action, delay, or failure of the Service to conduct such verification.

"(5) If the Secretary determines, after complying with the requirements of paragraph (4), that such an individual is not in a satisfactory immigration status—

"(A) the Secretary shall deny or terminate the individual's eligibility for financial assistance, and

"(B) the applicable fair hearing process shall be made available with respect to the individual.

In this subsection and subsection (e), the term 'Secretary' refers to the Secretary and to a public housing authority or other entity which makes financial assistance available.

"(e) The Secretary shall not take any compliance, disallowance, penalty, or other regulatory action against an entity with respect to any error in the entity's determination to make an individual eligible for financial assistance based on citizenship or immigration status—

"(1) if the entity has provided such eligibility based on a verification of satisfactory immigration status by the Immigration and Naturalization Service,

"(2) because the entity, under subsection (d)(4)(A)(ii), was required to provide a reasonable opportunity to submit documentation,

"(3) because the entity, under subsection (d)(4)(B)(ii), was required to wait for the response of the Immigration and Naturalization Service to the entity's request for official verification of the immigration status of the individual, or

"(4) because of a fair hearing process described in subsection (d)(5)(B)."

(4) UNDER TITLE IV EDUCATIONAL ASSISTANCE.—Section 484 of the Higher Education Act of 1965 (20 U.S.C. 1091) is amended by adding at the end the following new subsections:

"(c) The following conditions apply with respect to an individual's receipt of any grant, loan, or work assistance under this title as a student at an institution of higher education:

"(1)(A) There must be a declaration in writing to the institution by the student, under penalty of perjury, stating whether or not the student is a citizen or national of the United States, and, if the student is not a citizen or national of the United States, that the individual is in a satisfactory immigration status.

"(B) In this subsection, the term 'satisfactory immigration status' means an immigration status which does not make the student ineligible for a grant, loan, or work assistance under this title.

"(2) If the student is not a citizen or national of the United States, there must be presented to the institution either—

"(A) alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual's alien admission number or alien file number (or numbers if the individual has more than one number), or

"(B) such other documents as the institution determines (in accordance with guidelines of the Secretary) constitutes reasonable evidence indicating a satisfactory immigration status.

"(3) If the documentation described in paragraph (2)(A) is presented, the institution shall utilize the individual's alien file or alien admission number to verify with the Immigration and Naturalization Service the individual's immigration status through an automated or other system (designated by the Service for use with institutions) that—

"(A) utilizes the individual's name, file number, admission number, or other means permitting efficient verification, and

"(B) protects the individual's privacy to the maximum degree possible.

"(4) In the case of such an individual who is not a citizen or national of the United States, if the statement described in paragraph (1) is submitted but the

documentation required under paragraph (2) is not presented or if the documentation required under paragraph (2)(A) is presented but such documentation is not verified under paragraph (3)—

“(A) the institution—

“(i) shall provide a reasonable opportunity to submit to the institution evidence indicating a satisfactory immigration status, and

“(ii) may not delay, deny, reduce, or terminate the individual's eligibility for the grant, loan, or work assistance on the basis of the individual's immigration status until such a reasonable opportunity has been provided; and

“(B) if there are submitted documents which the institution determines constitutes reasonable evidence indicating such status—

“(i) the institution shall transmit to the Immigration and Naturalization Service photostatic or other similar copies of such documents for official verification,

“(ii) pending such verification, the institution may not delay, deny, reduce, or terminate the individual's eligibility for the grant, loan, or work assistance on the basis of the individual's immigration status, and

“(iii) the institution shall not be liable for the consequences of any action, delay, or failure of the Service to conduct such verification.

“(5) If the institution determines, after complying with the requirements of paragraph (4), that such an individual is not in a satisfactory immigration status—

“(A) the institution shall deny or terminate the individual's eligibility for such grant, loan, or work assistance, and

“(B) the applicable fair hearing process shall be made available with respect to the individual.

“(d) The Secretary shall not take any compliance, disallowance, penalty, or other regulatory action against an institution of higher education with respect to any error in the institution's determination to make an student eligible for a grant, loan, or work assistance based on citizenship or immigration status—

“(1) if the institution has provided such eligibility based on a verification of satisfactory immigration status by the Immigration and Naturalization Service,

“(2) because the institution, under subsection (c)(4)(A)(ii), was required to provide a reasonable opportunity to submit documentation,

“(3) because the institution, under subsection (c)(4)(B)(ii), was required to wait for the response of the Immigration and Naturalization Service to the institution's request for official verification of the immigration status of the student, or

“(4) because of a fair hearing process described in subsection (c)(5)(B).”.

(b) PROVIDING 100 PERCENT REIMBURSEMENT FOR COSTS OF IMPLEMENTATION AND OPERATION.—

(1) UNDER AFDC PROGRAM.—Section 403(a)(3) of the Social Security Act is amended by inserting before subparagraph (B) the following new subparagraph:

“(A) 100 percent of so much of such expenditures as are for the costs of the implementation and operation of the immigration status verification system described in section 1137(d).”.

(2) UNDER MEDICAID PROGRAM.—Section 1903(a) of such Act is amended by inserting after paragraph (3) the following new paragraph:

“(4) an amount equal to 100 percent of the sums expended during the quarter which are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus”.

(3) UNDER UNEMPLOYMENT COMPENSATION PROGRAM.—The first sentence of section 302(a) of such Act is amended by inserting before the period at the end the following: “, including 100 percent of so much of the reasonable expenditures of the State as are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1137(d).”.

(4) UNDER CERTAIN TERRITORIAL ASSISTANCE PROGRAMS.—Sections 3(a)(4), 1003(a)(3), 1403(a)(3), and 1603(a)(4) of the Social Security Act (as in effect without regard to section 301 of the Social Security Amendments of 1972) are each amended by redesignating subparagraph (B) as subparagraph (C) and inserting after subparagraph (A) the following new subparagraph:

“(B) 100 percent of so much of such expenditures as are for the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus”.

(5) UNDER THE FOOD STAMP PROGRAM.—Section 16 of the Food Stamp Act of 1977 (7 U.S.C. 2025) is amended by adding at the end the following new subsection:

“(h) The Secretary is authorized to pay to each State agency an amount equal to 100 per centum of the costs incurred by the State agency in implementing and operating the immigration status verification system described in section 1137(d) of the Social Security Act.”.

(6) UNDER HOUSING ASSISTANCE PROGRAMS.—The United States Housing Act of 1937 (42 U.S.C. 1437 et seq.) is amended by adding at the end the following new section:

“PAYMENT FOR IMPLEMENTATION OF IMMIGRATION STATUS VERIFICATION SYSTEM

“SEC. 20. The Secretary is authorized to pay to each public housing authority an amount equal to 100 percent of the costs incurred by the authority in implementing and operating the immigration status verification system under section 214(c) of the Housing and Community Development Act of 1980 with respect to financial assistance made available pursuant to this Act.”.

(c) EFFECTIVE DATES.—

(1) IMMIGRATION AND NATURALIZATION SERVICE ESTABLISHING VERIFICATION SYSTEM BY OCTOBER 1, 1987.—The Commissioner of Immigration and Naturalization shall implement a system for the verification of immigration status under paragraphs (3) and (4)(B)(i) of section 1137(d) of the Social Security Act (as amended by this section) so that the system is available to all the States by not later than October 1, 1987. Such system shall not be used by the Immigration and Naturalization Service for administrative (non-criminal) immigration enforcement purposes and shall be implemented in a manner that provides for verification of immigration status without regard to the sex, color, race, religion, or nationality of the individual involved.

(2) HIGHER MATCHING EFFECTIVE IN FISCAL YEAR 1988.—The amendments made by subsection (b) take effect on October 1, 1987.

(3) USE OF VERIFICATION SYSTEM REQUIRED IN FISCAL YEAR 1989.—The amendments made by subsection (a) take effect on October 1, 1988. States have until that date to begin complying with the requirements imposed by those amendments.

(4) FUNDS AUTHORIZED.—Such sums as may be necessary are authorized for the Immigration and Naturalization Service to carry out the purposes of this section.

TITLE II—LEGALIZATION

SEC. 201. LEGALIZATION OF STATUS.

(a) PROVIDING FOR LEGALIZATION PROGRAM.—Chapter 5 of title II is amended by inserting after section 245 (8 U.S.C. 1255) the following new section:

“ADJUSTMENT OF STATUS OF CERTAIN ENTRANTS BEFORE JANUARY 1, 1982, TO THAT OF PERSON ADMITTED FOR LAWFUL RESIDENCE

“SEC. 245A. (a) TEMPORARY RESIDENT STATUS.—The Attorney General shall adjust the status of an alien to that of an alien lawfully admitted for temporary residence if the alien meets the following requirements:

“(1) ENTRY, PHYSICAL PRESENCE, AND TIMELY APPLICATION.—

“(A) DURING APPLICATION PERIOD.—Except as provided in subparagraph (B), the alien must apply for such adjustment during the 18-month period beginning on a date (not later than 180 days after the date of enactment of this section) designated by the Attorney General.

“(B) APPLICATION WITHIN 30 DAYS OF SHOW-CAUSE ORDER.—An alien who, at any time during the first 17 months of the 18-month period described in subparagraph (A), is the subject of an order to show cause issued under section 242, must make application under this section not later than the end of the 30-day period beginning either on the first day of such 18-month period or on the date of the issuance of such order, whichever day is later.

“(C) TREATMENT OF CERTAIN CUBAN AND HAITIAN ENTRANTS.—For purposes of this subsection, an alien in the status of a Cuban and Haitian entrant described in paragraph (1) or (2)(A) of section 501(e) of Public Law 96-422 shall be considered to have entered the United States and to be in an unlawful status in the United States.

“(2) CONTINUOUS UNLAWFUL RESIDENCE SINCE 1982.—

"(B) shall be granted authorization to engage in employment in the United States and be provided an 'employment authorized' endorsement or other appropriate work permit.

"(2) DURING APPLICATION PERIOD.—The Attorney General shall provide that in the case of an alien who presents a nonfrivolous application for adjustment of status under subsection (a) during the application period, and until a final determination on the application has been made in accordance with this section, the alien—

"(A) may not be deported, and

"(B) shall be granted authorization to engage in employment in the United States and be provided an 'employment authorized' endorsement or other appropriate work permit.

"(f) ADMINISTRATIVE AND JUDICIAL REVIEW.—

"(1) ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review of a determination respecting an application for adjustment of status under this section except in accordance with this subsection.

"(2) ADMINISTRATIVE REVIEW.—

"(A) SINGLE LEVEL OF ADMINISTRATIVE APPELLATE REVIEW.—The Attorney General shall establish an appellate authority to provide for a single level of administrative appellate review of such a determination.

"(B) STANDARD FOR REVIEW.—Such administrative appellate review shall be based solely upon the administrative record established at the time of the determination on the application and upon such additional or newly discovered evidence as may not have been available at the time of the determination.

"(3) JUDICIAL REVIEW.—

"(A) LIMITATION TO REVIEW OF DEPORTATION.—There shall be judicial review of such a denial only in the judicial review of an order of deportation under section 106.

"(B) STANDARD FOR JUDICIAL REVIEW.—Such judicial review shall be based solely upon the administrative record established at the time of the review by the appellate authority and the findings of fact and determinations contained in such record shall be conclusive unless the applicant can establish abuse of discretion or that the findings are directly contrary to clear and convincing facts contained in the record considered as a whole.

"(g) REGULATIONS IMPLEMENTING SECTION.—The Attorney General, after consultation with the Committees on the Judiciary of the House of Representatives and of the Senate and with qualified designated entities, shall prescribe—

"(1) regulations establishing a definition of the term 'resided continuously', as used in this section, and the evidence needed to establish that an alien has resided continuously in the United States for purposes of this section, and

"(2) such other regulations as may be necessary to carry out this section.

Such regulations may be prescribed to take effect on an interim final basis if the Attorney General determines that this is necessary in order to implement this section in a timely manner.

"(h) TEMPORARY DISQUALIFICATION OF NEWLY LEGALIZED ALIENS FROM RECEIVING CERTAIN PUBLIC WELFARE ASSISTANCE.—

"(1) IN GENERAL.—During the five-year period beginning on the date an alien was granted lawful temporary resident status under subsection (a), and notwithstanding any other provision of law—

"(A) except as provided in paragraph (2), the alien is not eligible for—

"(i) any program of financial assistance furnished under Federal law (whether through grant, loan, guarantee, or otherwise) on the basis of financial need, as such programs are identified by the Attorney General in consultation with other appropriate heads of the various departments and agencies of Government,

"(ii) medical assistance under a State plan approved under title XIX of the Social Security Act, and

"(iii) assistance under the Food Stamp Act of 1977; and

"(B) a State or political subdivision therein may, to the extent consistent with subparagraph (A), provide that the alien is not eligible for the programs of financial assistance or for medical assistance described in subparagraph (A)(ii) furnished under the law of that State or political subdivision.

"(2) EXCEPTIONS.—Paragraph (1) shall not apply—

"(A) to a Cuban and Haitian entrant (as defined in paragraph (1) or (2)(A) of section 501(e) of Public Law 96-422, as in effect on April 1, 1983),

"(B) in the case of assistance furnished to an alien who is an aged, blind, or disabled individual (as defined in section 1614(a)(1) of the Social Security Act), or

"(C) in the case of medical assistance (i) for care and services provided to an alien who is under 18 years of age, (ii) for emergency services (as defined for purposes of section 1916(a)(2)(D) of the Social Security Act) or (iii) for services described in section 1916(a)(2)(B) of such Act (relating to services for pregnant women).

"(3) TREATMENT OF CERTAIN PROGRAMS.—Assistance furnished under any of the following provisions of law shall not be construed to be financial assistance described in paragraph (1)(A)(i):

"(A) The National School Lunch Act.

"(B) The Child Nutrition Act of 1966.

"(C) the Vocational Education Act of 1963.

"(D) Chapter 1 of the Education Consolidation and Improvement Act of 1981.

"(E) The Headstart-Follow Through Act.

"(F) The Job Training Partnership Act.

"(G) Subparts 4 and 5 of part A of title IV of the Higher Education Act of 1965.

"(H) The Public Health Service Act.

"(I) Title V of the Social Security Act.

"(4) ADJUSTMENT NOT AFFECTING FASCELL-STONE BENEFITS.—For the purpose of section 501 of the Refugee Education Assistance Act of 1980 (Public Law 96-122), assistance shall be continued under such section with respect to an alien without regard to the alien's adjustment of status under this section.

"(5) MODIFICATION OF MEDICAID REQUIREMENTS.—The eligibility, comparability, and any other State plan requirements of title XIX of the Social Security Act are superseded to the extent required to restrict the medical assistance in the manner described in this subsection. The Secretary of Health and Human Services, in coordination with the Attorney General, shall promulgate regulations in order to carry out this subsection.

"(i) DISSEMINATION OF INFORMATION ON LEGALIZATION PROGRAM.—Beginning not later than the date designated by the Attorney General under subsection (a)(1)(A), the Attorney General, in cooperation with designated entities, shall broadly disseminate in English and other appropriate languages information respecting the benefits which aliens may receive under this section and the requirements to obtain such benefits. Such information shall include—

"(1) information respecting the requirements that aliens with lawful temporary resident status would have to meet to have their status adjusted to permanent resident status under subsection (b)(1) and the facilities available to provide education and employment training and opportunities in order to meet such requirements;

"(2) information on the conditions under which temporary lawful resident status can be rescinded under subsection (b)(2); and

"(3) information on conditions for employment and foreign travel of aliens with lawful temporary resident status under subsection (b)(3)."

(b) TABLE OF CONTENTS AMENDMENT.—The table of contents for chapter 5 of title II is amended by inserting after the item relating to section 245 the following new item:

"Sec. 245A. Adjustment of status of certain entrants before January 1, 1982, to that of person admitted for lawful residence."

SEC. 202. CUBAN-HAITIAN ADJUSTMENT.

(a) ADJUSTMENT OF STATUS.—The status of any alien described in subsection (b) may be adjusted by the Attorney General, in the Attorney General's discretion and under such regulations as the Attorney General may prescribe, to that of an alien lawfully admitted for permanent residence if—

(1) the alien applies for such adjustment within two years after the date of the enactment of this Act;

(2) the alien is otherwise eligible to receive an immigrant visa and is otherwise admissible to the United States for permanent residence, except in determining such admissibility the grounds for exclusion specified in paragraphs (14), (15), (20), (21), (25), and (32) of section 212(a) of the Immigration and Nationality Act shall not apply;

(3) the alien is not an alien described in section 243(h)(2) of such Act;

(4) the alien is physically present in the United States on the date the application for such adjustment is filed; and

(5) the alien has continuously resided in the United States since January 1, 1982.

(b) **ALIENS ELIGIBLE FOR ADJUSTMENT OF STATUS.**—The benefits provided by subsection (a) shall apply to any alien—

(1) who has received an immigration designation as a Cuban/Haitian Entrant (Status Pending) as of the date of the enactment of this Act, or

(2) who is a national of Cuba or Haiti, who arrived in the United States before January 1, 1982, with respect to whom any record was established by the Immigration and Naturalization Service before January 1, 1982, and who (unless the alien filed an application for asylum with the Immigration and Naturalization Service before January 1, 1982) was not admitted to the United States as a non-immigrant.

(c) **NO EFFECT ON FASCELL-STONE BENEFITS.**—An alien who, as of the date of the enactment of this Act, is a Cuban and Haitian entrant for the purpose of section 501 of Public Law 96-422 shall continue to be considered such an entrant for such purpose without regard to any adjustment of status effected under this section.

(d) **RECORD OF PERMANENT RESIDENCE AS OF JANUARY 1, 1982.**—Upon approval of an alien's application for adjustment of status under subsection (a), the Attorney General shall establish a record of the alien's admission for permanent residence as of January 1, 1982.

(e) **NO OFFSET IN NUMBER OF VISAS AVAILABLE.**—When an alien is granted the status of having been lawfully admitted for permanent residence pursuant to this section, the Secretary of State shall not be required to reduce the number of immigrant visas authorized to be issued under the Immigration and Nationality Act and the Attorney General shall not be required to charge the alien any fee.

(f) **APPLICATION OF IMMIGRATION AND NATIONALITY ACT PROVISIONS.**—Except as otherwise specifically provided in this section, the definitions contained in the Immigration and Nationality Act shall apply in the administration of this section. Nothing contained in this section shall be held to repeal, amend, alter, modify, effect, or restrict the powers, duties, functions, or authority of the Attorney General in the administration and enforcement of such Act or any other law relating to immigration, nationality, or naturalization. The fact that an alien may be eligible to be granted the status of having been lawfully admitted for permanent residence under this section shall not preclude the alien from seeking such status under any other provision of law for which the alien may be eligible.

SEC. 203. UPDATING REGISTRY DATE TO JANUARY 1, 1976.

(a) **IN GENERAL.**—Section 249 (8 U.S.C. 1259) is amended—

(1) by striking out "JUNE 30, 1948" in the heading and inserting in lieu thereof "JANUARY 1, 1976", and

(2) by striking out "June 30, 1948" in paragraph (a) and inserting in lieu thereof "January 1, 1976".

(b) **CONFORMING AMENDMENT TO TABLE OF CONTENTS.**—The item in the table of contents relating to section 249 is amended by striking out "June 30, 1948", and inserting in lieu thereof "January 1, 1976".

(c) **CLARIFICATION.**—The numerical limitations of sections 201 and 202 of the Immigration and Nationality Act shall not apply to aliens provided lawful permanent resident status under section 249 of that Act.

SEC. 204. STATE LEGALIZATION ASSISTANCE.

(a) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out subsections (b) and (c) of this section (including State and local administrative costs) such sums as may be necessary for fiscal year 1987 and for each of the four succeeding fiscal years.

(b) **REIMBURSEMENT TO STATES FOR PUBLIC ASSISTANCE FOR ELIGIBLE LEGALIZED ALIENS.**—(1) Subject to the amounts provided in advance in appropriation Acts, the Secretary of Health and Human Services shall provide reimbursement to each State (as defined in paragraph (2)(A)) for 100 percent of the costs of programs of public assistance (as defined in paragraph (2)(B)) provided to any eligible legalized alien (as defined in paragraph (2)(C)).

(2) For purposes of this subsection:

(A) The term "State" has the meaning given such term in section 101(a)(36) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(36)).

(B) The term "programs of public assistance" means programs existing in a State or local jurisdiction which—

(i) provide for cash, medical, or other assistance designed to meet the basic subsistence or health needs of individuals or required in the interest of public health,

(ii) are generally available to needy individuals residing in the State or locality, and

(iii) receive funding from units of State or local government.

(C) The term "eligible legalized alien" means an alien who was granted lawful temporary resident status under section 245A(a) of the Immigration and Nationality Act, but only until the end of the five-year period beginning on the date the alien was granted such status.

(c) EDUCATIONAL ASSISTANCE.—Subject to the amounts provided in advance in appropriation Acts and in accordance with this section, the Secretary of Education shall make payments to State educational agencies for the purpose of assisting local educational agencies of that State in providing educational services for eligible legalized aliens (as defined in subsection (b)(2)(C)), but only to the extent such services are otherwise available to those residing in the State.

(d) CONSULTATION IN IMPLEMENTING SECTION.—The Secretary of Health and Human Services and the Secretary of Education shall consult with representatives of State and local governments in establishing regulations and guidelines to carry out this section.

TITLE III—REFORM OF LEGAL IMMIGRATION

PART A—TEMPORARY AGRICULTURAL WORKERS

SEC. 301. H-2A AGRICULTURAL WORKERS.

(a) PROVIDING NEW "H-2A" NONIMMIGRANT CLASSIFICATION FOR TEMPORARY AGRICULTURAL LABOR.—Paragraph (15)(H) of section 101(a) (8 U.S.C. 1101(a)) is amended by striking out "to perform temporary services or labor," in clause (ii) and inserting in lieu thereof "(a) to perform agricultural labor or services, as defined by the Secretary of Labor in regulations and including agricultural labor defined in section 3121(g) of the Internal Revenue Code of 1954 and agriculture as defined in section 3(f) of the Fair Labor Standards Act of 1938 (29 U.S.C. 203(f)), of a temporary or seasonal nature, or (b) to perform other temporary service or labor".

(b) INVOLVEMENT OF DEPARTMENTS OF LABOR AND AGRICULTURE IN H-2A PROGRAM.—Section 214(c) (8 U.S.C. 1184(c)) is amended by adding at the end the following: "For purposes of this subsection with respect to nonimmigrants described in section 101(a)(15)(H)(ii)(a), the term 'appropriate agencies of Government' means the Department of Labor and includes the Department of Agriculture. The provisions of section 216 shall apply to the question of importing any alien as a nonimmigrant under section 101(a)(15)(H)(ii)(a).".

(c) ADMISSION OF H-2A WORKERS.—(1) Chapter 2 of title II is amended by adding after section 215 the following new section:

"ADMISSION OF TEMPORARY H-2A WORKERS

"SEC. 216. (a) CONDITIONS FOR APPROVAL OF H-2A PETITION.—(1) A petition to import an alien as an H-2A worker (as defined in subsection (i)(2)) may not be approved by the Attorney General unless the petitioner has applied to the Secretary of Labor for a certification that—

"(A) there are not sufficient workers who are able, willing, and qualified, and who will be available at the time and place needed, to perform the labor or services involved in the petition, and

"(B) the employment of the alien in such labor or services will not adversely affect the wages and working conditions of workers in the United States similarly employed.

"(2) The Secretary of Labor may require by regulation, as a condition of issuing the certification, the payment of a fee to recover the reasonable costs of processing applications for certification.

"(b) CONDITIONS FOR DENIAL OF LABOR CERTIFICATION.—The Secretary of Labor may not issue a certification under subsection (a) with respect to an employer if the conditions described in that subsection are not met or if any of the following conditions are met:

"(1) There is a strike or lockout in the course of a labor dispute which, under the regulations, precludes such certification.

"(2)(A) The employer during the previous two-year period employed H-2A workers and the Secretary of Labor has determined, after notice and opportunity for a hearing, that the employer at any time during that period substantially

violated a material term or condition of the labor certification with respect to the employment of domestic or nonimmigrant workers.

"(B) No employer may be denied certification under subparagraph (A) for more than three years for any violation described in such subparagraph.

"(3) The employer has not provided the Secretary with satisfactory assurances that if the employment for which the certification is sought is not covered by State workers' compensation law, the employer will provide, at no cost to the worker, insurance covering injury and disease arising out of and in the course of the worker's employment which will provide benefits at least equal to those provided under the State workers' compensation law for comparable employment.

"(4) The Secretary determines that the employer has not made positive recruitment efforts within a multi-state region of traditional or expected labor supply where the Secretary finds that there are a significant number of qualified United States workers who, if recruited, would be willing to make themselves available for work at the time and place needed. Positive recruitment under this paragraph is in addition to, and shall be conducted within the same time period as, the circulation through the interstate employment service system of the employer's job offer. The obligation to engage in positive recruitment under this paragraph shall terminate on the date the H-2A workers depart for the employer's place of employment.

"(C) SPECIAL RULES FOR CONSIDERATION OF APPLICATIONS.—The following rules shall apply in the case of the filing and consideration of an application for a labor certification under this section:

"(1) DEADLINE FOR FILING APPLICATIONS.—The Secretary of Labor may not require that the application be filed more than 60 days before the first date the employer requires the labor or services of the H-2A worker.

"(2) NOTICE WITHIN SEVEN DAYS OF DEFICIENCIES.—(A) The employer shall be notified in writing within seven days of the date of filing if the application does not meet the standards (other than that described in subsection (a)(1)(A)) for approval.

"(B) If the application does not meet such standards, the notice shall include the reasons therefor and the Secretary shall provide an opportunity for the prompt resubmission of a modified application.

"(3) ISSUANCE OF CERTIFICATION.—(A) The Secretary of Labor shall make, not later than 20 days before the date such labor or services are first required to be performed, the certification described in subsection (a)(1) if—

"(i) the employer has complied with the criteria for certification (including criteria for the recruitment of eligible individuals as prescribed by the Secretary), and

"(ii) the employer does not actually have, or has not been provided with referrals of, qualified eligible individuals who have indicated their availability to perform such labor or services on the terms and conditions of a job offer which meets the requirements of the Secretary.

In considering the question of whether a specific qualification is appropriate in a job offer, the Secretary shall apply the normal and accepted qualifications required by non-H-2A-employers in the same or comparable occupations and crops.

"(B)(i) For a period of 3 years subsequent to the effective date of this section, labor certifications shall remain effective only if, from the time the foreign worker departs for the employer's place of employment, the employer will provide employment to any qualified United States worker who applies to the employer until 50 percent of the period of the work contract, under which the foreign worker who is in the job was hired, has elapsed. In addition, the employer will offer to provide benefits, wages and working conditions required pursuant to this section and regulations.

"(ii) The requirement of clause (i) shall not apply to any employer who—

"(I) did not, during any calendar quarter during the preceding calendar year, use more than 500 man-days of agricultural labor, as defined in section 3(u) of the Fair Labor Standards Act of 1938 (29 U.S.C. 203(u)),

"(II) is not a member of an association which has petitioned for certification under this section for its members, and

"(III) has not otherwise associated with other employers who are petitioning for temporary foreign workers under this section.

"(iii) Six months before the end of the 3-year period described in clause (i), the Secretary of Labor shall consider the findings of the report mandated by section 403(a)(4)(D) of the Immigration Control and Legalization Amendments Act of

1986 as well as other relevant materials, including evidence of benefits to United States workers and costs to employers, addressing the advisability of continuing a policy which requires an employer, as a condition for certification under this section, to continue to accept qualified, eligible United States workers for employment after the date the H-2A workers depart for work with the employer. The Secretary's review of such findings and materials shall lead to the issuance of findings in furtherance of the Congressional policy that aliens not be admitted under this section unless there are not sufficient workers in the United States who are able, willing, and qualified to perform the labor or service needed and that the employment of the aliens in such labor or services will not adversely affect the wages and working conditions of workers in the United States similarly employed. In the absence of the enactment of Federal legislation prior to three months before the end of the 3-year period described in clause (i) which addresses the subject matter of this subparagraph, the Secretary shall immediately publish the findings required by this clause, and shall promulgate, on an interim or final basis, regulations based on his findings which shall be effective no later than three years from the effective date of this section.

"(iv) In complying with clause (i) of this subparagraph, an association shall be allowed to refer or transfer workers among its members: *Provided*, That for purposes of this section an association acting as an agent for its members shall not be considered a joint employer merely because of such referral or transfer.

"(v) United States workers referred or transferred pursuant to clause (iv) of this subparagraph shall not be treated disparately.

"(vi) An employer shall not be liable for payments under section 655.202(b)(6) of title 20, Code of Federal Regulations (or any successor regulation) with respect to an H-2A worker who is displaced due to compliance with the requirement of this subparagraph, if the Secretary of Labor certifies that the H-2A worker was displaced because of the employer's compliance with clause (i) of this subparagraph.

"(vii)(I) No person or entity shall willfully and knowingly withhold domestic workers prior to the arrival of H-2A workers in order to force the hiring of domestic workers under clause (i).

"(II) Upon the receipt of a complaint by an employer that a violation of subclause (I) has occurred the Secretary shall immediately investigate. He shall within 36 hours of the receipt of the complaint issue findings concerning the alleged violation. Where the Secretary finds that a violation has occurred, he shall immediately suspend the application of clause (i) of this subparagraph with respect to that certification for that date of need.

"(4) HOUSING.—Employers shall furnish housing in accordance with regulations. The employer shall be permitted at the employer's option to provide housing meeting applicable Federal standards for temporary labor camps or to secure housing which meets the local standards for rental and/or public accommodations or other substantially similar class of habitation: *Provided*, That in the absence of applicable local standards, State standards for rental and/or public accommodations or other substantially similar class of habitation shall be met: *Provided further*, That in the absence of applicable local or State standards, Federal temporary labor camp standards shall apply: *Provided further*, That the Secretary of Labor shall issue regulations which address the specific requirements of housing for employees principally engaged in the range production of livestock: *Provided further*, That when it is the prevailing practice in the area and occupation of intended employment to provide family housing, family housing shall be provided to workers with families who request it: *And provided further*, That nothing in this paragraph shall require an employer to provide or secure housing for workers who are not entitled to it under the temporary labor certification regulations in effect on June 1, 1986.

"(d) ROLES OF AGRICULTURAL ASSOCIATIONS.—

"(1) PERMITTING FILING BY AGRICULTURAL ASSOCIATIONS.—A petition to import an alien as a temporary agricultural worker, and an application for a labor certification with respect to such a worker, may be filed by an association of agricultural producers which use agricultural services.

"(2) TREATMENT OF ASSOCIATIONS ACTING AS EMPLOYERS.—If an association is a joint or sole employer of temporary agricultural workers, the certifications granted under this section to the association may be used for the certified job opportunities of any of its producer members and such workers may be transferred among its producer members to perform agricultural services of a temporary or seasonal nature for which the certifications were granted.

“(3) TREATMENT OF VIOLATIONS.—

“(A) MEMBER’S VIOLATION DOES NOT NECESSARILY DISQUALIFY ASSOCIATION OR OTHER MEMBERS.—If an individual producer member of a joint employer association is determined to have committed an act that under subsection (b)(2) results in the denial of certification with respect to the member, the denial shall apply only to that member of the association unless the Secretary determines that the association or other member participated in, had knowledge of, or reason to know of, the violation.

“(B) ASSOCIATION’S VIOLATION DOES NOT NECESSARILY DISQUALIFY MEMBERS.—(i) If an association representing agricultural producers as a joint employer is determined to have committed an act that under subsection (b)(2) results in the denial of certification with respect to the association, the denial shall apply only to the association and does not apply to any individual producer member of the association unless the Secretary determines that the member participated in, had knowledge of, or reason to know of, the violation.

“(ii) If an association of agricultural producers certified as a sole employer is determined to have committed an act that under subsection (b)(2) results in the denial of certification with respect to the association, no individual producer member of such association may be the beneficiary of the services of temporary alien agricultural workers admitted under this section in the commodity and occupation in which such aliens were employed by the association which was denied certification during the period such denial is in force, unless such producer member employs such aliens in the commodity and occupation in question directly or through an association which is a joint employer of such workers with the producer member.

“(e) EXPEDITED ADMINISTRATIVE APPEALS OF CERTAIN DETERMINATIONS.—(1) Regulations shall provide for an expedited procedure for the review of a denial of certification under subsection (a)(1) or a revocation of such a certification or, at the applicant’s request, for a de novo administrative hearing respecting the denial or revocation.

“(2) The Secretary of Labor shall expeditiously, but in no case later than 72 hours after the time a new determination is requested, make a new determination on the request for certification in the case of an H-2A worker if able, willing, and qualified eligible individuals are not actually available at the time such labor or services are required and a certification was denied in whole or in part because of the availability of qualified workers. If the employer asserts that any eligible individual who has been referred is not able, willing, or qualified, the burden of proof is on the employer to establish that the individual referred is not able, willing, or qualified because of employment-related reasons.

“(f) VIOLATORS DISQUALIFIED FOR 5 YEARS.—An alien may not be admitted to the United States as a temporary agricultural worker if the alien was admitted to the United States as such a worker within the previous five-year period and the alien during that period violated a term or condition of such previous admission.

“(g) AUTHORIZATIONS OF APPROPRIATIONS.—(1) There are authorized to be appropriated for each fiscal year, beginning with fiscal year 1987, \$10,000,000 for the purposes—

“(A) of recruiting domestic workers for temporary labor and services which might otherwise be performed by nonimmigrants described in section 101(a)(15)(H)(ii)(a), and

“(B) of monitoring terms and conditions under which such nonimmigrants (and domestic workers employed by the same employers) are employed in the United States.

“(2) The Secretary of Labor is authorized to take such actions, including imposing appropriate penalties and seeking appropriate injunctive relief and specific performance of contractual obligations, as may be necessary to assure employer compliance with terms and conditions of employment under this section.

“(3) There are authorized to be appropriated for each fiscal year, beginning with fiscal year 1987, such sums as may be necessary for the purpose of enabling the Secretary of Labor to make determinations and certifications under this section and under section 212(a)(14).

“(4) There are authorized to be appropriated for each fiscal year, beginning with fiscal year 1987, such sums as may be necessary for the purposes of enabling the Secretary of Agriculture to carry out the Secretary’s duties and responsibilities under this section.

“(h) MISCELLANEOUS PROVISIONS.—(1) The Attorney General shall provide for such endorsement of entry and exit documents of nonimmigrants described in section

101(a)(15)(H)(ii) as may be necessary to carry out this section and to provide notice for purposes of section 274A.

"(2) The provisions of subsections (a) and (c) of section 214 and the provisions of this section preempt any State or local law regulating admissibility of nonimmigrant workers.

"(i) DEFINITIONS.—For purposes of this section:

"(1) The term 'eligible individual' means, with respect to employment, an individual who is not an unauthorized alien (as defined in section 274A(g)) with respect to that employment.

"(2) The term 'H-2A worker' means a nonimmigrant described in section 101(a)(15)(H)(ii)(a)."

(2) Section 3306(c)(1)(B) of the Internal Revenue Code of 1954 is amended by striking out "before January 1, 1988,".

(d) EFFECTIVE DATE.—The amendments made by this section apply to petitions and applications filed under sections 214(c) and 216 of the Immigration and Nationality Act on or after the first day of the seventh month beginning after the date of the enactment of this Act (hereinafter in this section referred to as the "effective date").

(e) REGULATIONS.—The Attorney General, in consultation with the Secretary of Labor and the Secretary of Agriculture, shall approve all regulations to be issued implementing sections 101(a)(15)(H)(ii)(a) and 216 of the Immigration and Nationality Act. Notwithstanding any other provision of law, final regulations to implement such sections shall first be issued, on an interim or other basis, not later than the effective date.

(f) SENSE OF CONGRESS RESPECTING CONSULTATION WITH MEXICO.—It is the sense of Congress that the President should establish an advisory commission which shall consult with the Governments of Mexico and of other appropriate countries and advise the Attorney General regarding the operation of the alien temporary worker program established under section 216 of the Immigration and Nationality Act.

(g) CONFORMING AMENDMENT TO TABLE OF CONTENTS.—The table of contents is amended by inserting after the item relating to section 215 the following new item:

"Sec. 216. Admission of temporary H-2A workers."

SEC. 302. PERMANENT RESIDENCE FOR CERTAIN SPECIAL AGRICULTURAL WORKERS.

(a) IN GENERAL.—Chapter 1 of title II is amended by adding at the end the following new section:

"SPECIAL AGRICULTURAL WORKERS

"SEC. 210. (a) PERMANENT RESIDENCE.—The Attorney General shall adjust the status of an alien to that of an alien lawfully admitted for permanent residence if the Attorney General determines that the alien meets the following requirements:

"(1) APPLICATION PERIOD.—The alien must apply for such adjustment during the 18-month period beginning on the first day of the seventh month that begins after the date of enactment of this section.

"(2) PERFORMANCE OF SEASONAL AGRICULTURAL SERVICES.—The alien must establish that he performed seasonal agricultural services in the United States for at least 60 man-days during the 12-month period ending on May 1, 1986. For purposes of the previous sentence, performance of seasonal agricultural services in the United States for more than one employer on any one day shall be counted as performance of services for only 1 man-day.

"(3) ADMISSIBLE AS IMMIGRANT.—The alien must establish that he is admissible to the United States as an immigrant, except as otherwise provided under subsection (c)(2).

"(b) APPLICATIONS FOR ADJUSTMENT OF STATUS.—

"(1) TO WHOM MAY BE MADE.—

"(A) WITHIN THE UNITED STATES.—The Attorney General shall provide that applications for adjustment of status under subsection (a) may be filed—

"(i) with the Attorney General, or

"(ii) with a designated entity (designated under paragraph (2)), but only if the applicant consents to the forwarding of the application to the Attorney General.

"(B) OUTSIDE THE UNITED STATES.—The Attorney General, in cooperation with the Secretary of State, shall provide a procedure whereby an alien may apply for adjustment of status under subsection (a) at an appropriate consular office outside the United States. If the alien otherwise qualifies for such adjustment, the Attorney General shall provide such documentation of

authorization to enter the United States and to have the alien's status adjusted upon entry as may be necessary to carry out the provisions of this section.

"(2) DESIGNATION OF ENTITIES TO RECEIVE APPLICATIONS.—For purposes of receiving applications under this section, the Attorney General—

"(A) shall designate qualified voluntary organizations and other qualified State, local, community, farm labor organizations, and associations of agricultural employers, and

"(B) may designate such other persons as the Attorney General determines are qualified and have substantial experience, demonstrated competence, and traditional long-term involvement in the preparation and submittal of applications for adjustment of status under section 209 or 245, Public Law 89-732, or Public Law 95-145.

"(3) PROOF OF ELIGIBILITY.—An alien may establish that he meets the requirement of subsection (a)(2) through government employment records, records supplied by employers or collective bargaining organizations, and such other reliable documentation as the alien may provide. The Attorney General shall establish special procedures to credit properly work in cases in which an alien was employed under an assumed name.

"(4) TREATMENT OF APPLICATIONS BY DESIGNATED ENTITIES.—Each designated entity must agree to forward to the Attorney General applications filed with it in accordance with paragraph (1)(A)(ii) but not to forward to the Attorney General applications filed with it unless the applicant has consented to such forwarding. No such entity may make a determination required by this section to be made by the Attorney General.

"(5) LIMITATION ON ACCESS TO INFORMATION.—Files and records prepared for purposes of this section by designated entities operating under this section are confidential and the Attorney General and the Service shall not have access to such files or records relating to an alien without the consent of the alien.

"(6) CONFIDENTIALITY OF INFORMATION.—Neither the Attorney General, nor any other official or employee of the Department of Justice, or bureau or agency thereof, may—

"(A) use the information furnished pursuant to an application filed under this section for any purpose other than to make a determination on the application or for enforcement of paragraph (7),

"(B) make any publication whereby the information furnished by any particular individual can be identified, or

"(C) permit anyone other than the sworn officers and employees of the Department or bureau or agency or, with respect to applications filed with a designated entity, that designated entity, to examine individual applications.

Anyone who uses, publishes, or permits information to be examined in violation of this paragraph shall be fined in accordance with title 18, United States Code, or imprisoned not more than five years, or both.

"(7) PENALTIES FOR FALSE STATEMENTS IN APPLICATIONS.—

"(A) CRIMINAL PENALTY.—Whoever—

"(i) files an application for adjustment of status under this section and knowingly and willfully falsifies, conceals, or covers up a material fact or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, or

"(ii) creates or supplies a false writing or document for use in making such an application, shall be fined in accordance with title 18, United States Code, or imprisoned not more than five years, or both.

"(B) EXCLUSION.—An alien who is convicted of a crime under subparagraph (A) shall be considered to be inadmissible to the United States on the ground described in section 212(a)(19).

"(c) WAIVER OF NUMERICAL LIMITATIONS AND CERTAIN GROUNDS FOR EXCLUSION.—

"(1) NUMERICAL LIMITATIONS DO NOT APPLY.—The numerical limitations of section 201 and 202 shall not apply to the adjustment of aliens to lawful permanent resident status under this section.

"(2) WAIVER OF GROUNDS FOR EXCLUSION.—In the determination of an alien's admissibility under subsection (a)(3)—

"(A) GROUNDS OF EXCLUSION NOT APPLICABLE.—The provisions of paragraphs (14), (20), (21), (25), and (32) of section 212(a) shall not apply.

“(B) WAIVER OF OTHER GROUNDS.—

“(i) IN GENERAL.—Except as provided in clause (ii), the Attorney General may waive any other provision of section 212(a) in the case of individual aliens for humanitarian purposes, to assure family unity, or when it is otherwise in the public interest.

“(ii) GROUNDS THAT MAY NOT BE WAIVED.—The following provisions of section 212(a) may not be waived by the Attorney General under clause (i):

“(I) Paragraph (9) and (10) (relating to criminals).

“(II) Paragraph (15) (relating to aliens likely to become public charges).

“(III) Paragraph (23) (relating to drug offenses), except for so much of such paragraph as relates to a single offense of simple possession of 30 grams or less of marihuana.

“(IV) Paragraphs (27), (28), and (29) (relating to national security and members of certain organizations).

“(V) Paragraph (33) (relating to those who assisted in the Nazi persecutions).

“(C) SPECIAL RULE FOR DETERMINATION OF PUBLIC CHARGE.—An alien is not ineligible for adjustment of status under this section due to being inadmissible under section 212(a)(15) if the alien demonstrates a history of employment in the United States evidencing self-support without reliance on public cash assistance.

“(d) TEMPORARY STAY OF EXCLUSION OR DEPORTATION AND WORK AUTHORIZATION FOR CERTAIN APPLICANTS.—

“(1) BEFORE APPLICATION PERIOD.—The Attorney General shall provide that in the case of an alien who is apprehended before the beginning of the application period described in subsection (a)(1) and who can establish a nonfrivolous case of eligibility to have his status adjusted under subsection (a) (but for the fact that he may not apply for such adjustment until the beginning of such period), until the alien has had the opportunity during the first 30 days of the application period to complete the filing of an application for adjustment, the alien—

“(A) may not be excluded or deported, and

“(B) shall be granted authorization to engage in employment in the United States and be provided an ‘employment authorized’ endorsement or other appropriate work permit.

“(2) DURING APPLICATION PERIOD.—The Attorney General shall provide that in the case of an alien who presents a nonfrivolous application for adjustment of status under subsection (a) during the application period, and until a final determination on the application has been made in accordance with this section, the alien—

“(A) may not be excluded or deported, and

“(B) shall be granted authorization to engage in employment in the United States and be provided an ‘employment authorized’ endorsement or other appropriate work permit.

“(e) ADMINISTRATIVE AND JUDICIAL REVIEW.—

“(1) ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review of a determination respecting an application for adjustment of status under this section except in accordance with this subsection.

“(2) ADMINISTRATIVE REVIEW.—

“(A) SINGLE LEVEL OF ADMINISTRATIVE APPELLATE REVIEW.—The Attorney General shall establish an appellate authority to provide for a single level of administrative appellate review of such a determination.

“(B) STANDARD FOR REVIEW.—Such administrative appellate review shall be based solely upon the administrative record established at the time of the determination on the application and upon such additional or newly discovered evidence as may not have been available at the time of the determination.

“(3) JUDICIAL REVIEW.—

“(A) LIMITATION TO REVIEW OF EXCLUSION OR DEPORTATION.—There shall be judicial review of such a denial only in the judicial review of an order of exclusion or deportation under section 106.

“(B) STANDARD FOR JUDICIAL REVIEW.—Such judicial review shall be based solely upon the administrative record established at the time of the review by the appellate authority and the findings of fact and determinations contained in such record shall be conclusive unless the applicant can establish

abuse of discretion or that the findings are directly contrary to clear and convincing facts contained in the record considered as a whole.

“(f) TREATMENT OF SPECIAL AGRICULTURAL WORKERS.—For all purposes an alien whose status is adjusted under this section to that of an alien lawfully admitted for permanent residence, such status not having changed, shall be considered to be an alien lawfully admitted for permanent residence (within the meaning of section 101(a)(20)).

“(g) SEASONAL AGRICULTURAL SERVICES DEFINED.—In this section, the term ‘seasonal agricultural services’ means the performance of field work related to planting, cultural practices, cultivating, growing and harvesting of fruits and vegetables of every kind and other perishable commodities, as defined in regulations by the Secretary of Agriculture.”

(b) CLERICAL AMENDMENT.—The table of contents is amended by inserting after the item relating to section 209 the following new item:

“Sec. 210. Special agricultural workers.”.

SEC. 303. DETERMINATIONS OF AGRICULTURAL LABOR SHORTAGES AND ADMISSION OF ADDITIONAL SPECIAL AGRICULTURAL WORKERS.

(a) IN GENERAL.—Chapter 1 of title II is amended by adding after section 210 (added by section 302 of this title) the following new section:

“DETERMINATION OF AGRICULTURAL LABOR SHORTAGES AND ADMISSION OF ADDITIONAL SPECIAL AGRICULTURAL WORKERS

“SEC. 210A. (a) DETERMINATION OF NEED TO ADMIT ADDITIONAL SPECIAL AGRICULTURAL WORKERS.—

“(1) IN GENERAL.—Before the beginning of each fiscal year (beginning with fiscal year 1990), the Secretaries of Labor and Agriculture (in this section referred to as the ‘Secretaries’) shall jointly determine the number (if any) of additional aliens who should be admitted to the United States or who should otherwise acquire the status of aliens lawfully admitted for permanent residence under this section during the fiscal year to meet a shortage of workers to perform seasonal agricultural services in the United States during the year. Such number is, in this section, referred to as the ‘shortage number’.

“(2) OVERALL DETERMINATION.—The shortage number is—

“(A) the anticipated need for special agricultural workers (as determined under paragraph (3)) for the fiscal year, minus

“(B) the supply of such workers (as determined under paragraph (4)) for that year,

divided by the factor (determined under paragraph (5)) for man-days per worker.

“(3) DETERMINATION OF NEED.—For purposes of paragraph (2)(A), the anticipated need for special agricultural workers for a fiscal year is determined as follows:

“(A) BASE.—The Secretaries shall jointly estimate, using statistically valid methods, the number of man-days of labor performed in seasonal agricultural services in the United States in the previous fiscal year.

“(B) ADJUSTMENT FOR CROP LOSSES AND CHANGES IN INDUSTRY.—The Secretaries shall jointly—

“(i) increase such number by the number of man-days of labor in seasonal agricultural services in the United States that would have been needed in the previous fiscal year to avoid any crop damage or other loss that resulted from the unavailability of labor, and

“(ii) adjust such number to take into account the projected growth or contraction in the requirements for seasonal agricultural services as a result of—

“(I) growth or contraction in the seasonal agriculture industry, and

“(II) the use of technologies and personnel practices that affect the need for, and retention of, workers to perform such services.

“(4) DETERMINATION OF SUPPLY.—For purposes of paragraph (2)(B), the anticipated supply of special agricultural workers for a fiscal year is determined as follows:

“(A) BASE.—The Secretaries shall use the number estimated under paragraph (3)(A).

“(B) ADJUSTMENT FOR RETIREMENTS AND INCREASED RECRUITMENT.—The Secretaries shall jointly—

"(i) decrease such number by the number of man-days of labor in seasonal agricultural services in the United States that will be lost due to retirement and movement of workers out of performance of seasonal agricultural services, and

"(ii) increase such number by the number of additional man-days of labor in seasonal agricultural services in the United States that can reasonably be expected to result from the availability of able, willing, qualified, and unemployed special agricultural workers, rural low skill, or manual, laborers, and domestic agricultural workers.

"(C) BASES FOR INCREASED NUMBER.—In making the adjustment under subparagraph (B)(ii), the Secretaries shall consider—

"(i) the effect, if any, that improvements in wages and working conditions offered by employers will have on the availability of workers to perform seasonal agricultural services, taking into account the adverse effect, if any, of such improvements in wages and working conditions on the economic competitiveness of the perishable agricultural industry,

"(ii) the effect, if any, of enhanced recruitment efforts by the employers of such workers and government employment services in the traditional and expected areas of supply of such workers, and

"(iii) the number of able, willing and qualified individuals who apply for employment opportunities in seasonal agricultural services listed with offices of government employment services.

"(D) CONSTRUCTION.—Nothing in this subsection shall be deemed to require any individual employer to pay any specified level of wages, to provide any specified working conditions, or to provide for any specified recruitment of workers.

"(5) DETERMINATION OF MAN-DAY PER WORKER FACTOR.—

"(A) FISCAL YEAR 1990.—For fiscal year 1990—

"(i) IN GENERAL.—Subject to clause (ii), for purposes of paragraph (2) the factor under this paragraph is the average number, as determined by the Director of the Bureau of the Census under subsection (b)(3)(A)(ii), of man-days of seasonal agricultural services performed in the United States in fiscal year 1989 by special agricultural workers whose status is adjusted under section 210 and who performed seasonal agricultural services in the United States at any time during the fiscal year.

"(ii) LACK OF ADEQUATE INFORMATION.—If the Director determines that—

"(I) the information reported under subsection (b)(2)(A) is not adequate to make a reasonable determination of the average number described in clause (i), but

"(II) the inadequacy of the information is not due to the refusal or failure of employers to report the information required under subsection (b)(2)(A),

the factor under this paragraph is 80.

"(B) FISCAL YEAR 1991.—For purposes of paragraph (2) for fiscal year 1991, the factor under this paragraph is the average number, as determined by the Director of the Bureau of the Census under subsection (b)(3)(A)(ii), of man-days of seasonal agricultural services performed in the United States in fiscal year 1990 by special agricultural workers who obtained lawful permanent resident status under this section.

"(C) FISCAL YEAR 1992 AND THEREAFTER.—For purposes of paragraph (2) for fiscal year 1992 and each fiscal year thereafter, the factor under this paragraph is the average number, as determined by the Director of the Bureau of the Census under subsection (b)(3)(A)(ii), of man-days of seasonal agricultural services performed in the United States in each of the two previous fiscal years by special agricultural workers who obtained lawful permanent resident status under this section during either of such fiscal years.

"(6) EMERGENCY PROCEDURE FOR INCREASE IN SHORTAGE NUMBER.—

"(A) REQUESTS.—After the beginning of a fiscal year, a group or association representing employers (and potential employers) of individuals who perform seasonal agricultural services may request the Secretaries to increase the shortage number for the fiscal year based upon a showing that extraordinary, unusual, and unforeseen circumstances have resulted in a significant increase in the shortage number due to (i) a significant increase in the need for special agricultural workers in the year, (ii) a significant

decrease in the availability of able, willing, and qualified workers to perform seasonal agricultural services, or (iii) a significant decrease (below the factor used for purposes of paragraph (5)) in the number of man-days of seasonal agricultural services performed by aliens who were recently admitted (or whose status was recently adjusted) under this section.

“(B) NOTICE OF EMERGENCY PROCEDURE.—Not later than 3 days after the date the Secretaries receive a request under subparagraph (A), the Secretaries shall provide for notice in the Federal Register of the substance of the request and shall provide an opportunity for interested parties to submit information to the Secretaries on a timely basis respecting the request.

“(C) PROMPT DETERMINATION ON REQUEST.—The Secretaries, not later than 21 days after the date of the receipt of such a request and after consideration of any information submitted on a timely basis with respect to the request, shall make and publish in the Federal Register their determination on the request. The request shall be granted, and the shortage number for the fiscal year shall be increased, to the extent that the Secretaries determine that such an increase is justified based upon the showing and circumstances described in subparagraph (A) and that such an increase takes into account reasonable recruitment efforts having been undertaken.

“(7) PROCEDURE FOR DECREASING MAN-DAYS OF SEASONAL AGRICULTURAL SERVICES REQUIRED IN THE CASE OF OVER-SUPPLY OF WORKERS.—

“(A) REQUESTS.—After the beginning of a fiscal year, a group of special agricultural workers may request the Secretaries to decrease the number of man-days required under subparagraphs (A) and (B) of subsection (d)(2) with respect to the fiscal year based upon a showing that extraordinary, unusual, and unforeseen circumstances have resulted in a significant decrease in the shortage number due to (i) a significant decrease in the need for special agricultural workers in the year, (ii) a significant increase in the availability of able, willing, and qualified workers to perform seasonal agricultural services, or (iii) a significant increase (above the factor used for purposes of paragraph (5)) in the number of man-days of seasonal agricultural services performed by aliens who were recently admitted (or whose status was recently adjusted) under this section.

“(B) NOTICE OF REQUEST.—Not later than 3 days after the date the Secretaries receive a request under subparagraph (A), the Secretaries shall provide for notice in the Federal Register of the substance of the request and shall provide an opportunity for interested parties to submit information to the Secretaries on a timely basis respecting the request.

“(C) DETERMINATION ON REQUEST.—The Secretaries, before the end of the fiscal year involved and after consideration of any information submitted on a timely basis with respect to the request, shall make and publish in the Federal Register their determination on the request. The request shall be granted, and the number of man-days specified in subparagraphs (A) and (B) of subsection (d)(2) for the fiscal year shall be reduced by the same proportion as the Secretaries determine that a decrease in the shortage number is justified based upon the showing and circumstances described in subparagraph (A).

“(b) NUMERICAL LIMITATION ON ADMISSION OF ADDITIONAL SPECIAL AGRICULTURAL WORKERS.—

“(1) NUMERICAL LIMITATION.—

“(A) FISCAL YEAR 1990.—The numerical limitation on the number of aliens who may be admitted under subsection (c)(1) or who otherwise may acquire lawful permanent residence under such subsection for fiscal year 1990 is—

“(i) 95 percent of the number of individuals whose status was adjusted under section 210(a), minus

“(ii) the number determined under paragraph (3)(A) for fiscal year 1989 (as adjusted in accordance with subparagraph (D)).

“(B) FISCAL YEARS 1991, 1992, 1993, AND 1994.—The numerical limitation on the number of aliens who may be admitted under subsection (c)(1) or who otherwise may acquire lawful permanent residence under such subsection for fiscal year 1991, 1992, 1993, or 1994, is—

“(i) 90 percent of the number described in this clause for the previous fiscal year (or, for fiscal year 1991, the number described in subparagraph (A)(i)), minus

"(ii) the number determined under paragraph (3)(A) for the previous fiscal year (as adjusted in accordance with subparagraph (D)).

"(C) FISCAL YEARS AFTER 1994.—The numerical limitation on the number of aliens who may be admitted under subsection (c)(1) or who otherwise may acquire lawful permanent residence under such subsection for a fiscal year after fiscal year 1994 is—

"(i) 95 percent of the number described in this clause for the previous fiscal year (or, for fiscal year 1995, the number described in subparagraph (B)(i)), minus

"(ii) the number determined under paragraph (3)(A)(i) for the previous fiscal year (as adjusted in accordance with subparagraph (D)).

"(D) ADJUSTMENT TO TAKE INTO ACCOUNT CHANGE IN NUMBER OF H-2 AGRICULTURAL WORKERS.—The number used under subparagraph (A)(ii), (B)(ii), or (C)(ii) (as the case may be) shall be increased or decreased to reflect any numerical increase or decrease, respectively, in the number of aliens admitted to perform temporary seasonal agricultural services (as defined in subsection (f)(2)) under section 101(a)(15)(H)(ii)(a) in the fiscal year compared to such number in the previous fiscal year.

"(2) REPORTING OF INFORMATION ON EMPLOYMENT.—In the case of a person or entity who employs, during a fiscal year in seasonal agricultural services, a special agricultural worker—

"(A) whose status was adjusted under section 210, the person or entity shall furnish the Director of the Bureau of the Census with a certificate (at a time and in a form approved by the Attorney General) of the number of man-days of employment performed by the alien in seasonal agricultural services during the fiscal year, or

"(B) who was admitted or whose status was adjusted under this section, the person or entity shall furnish the alien and the Director with a certificate (at a time and in a form approved by the Attorney General) of the number of man-days of employment performed by the alien in seasonal agricultural services during the fiscal year.

"(3) ANNUAL DETERMINATION OF EMPLOYMENT OF SPECIAL AGRICULTURAL WORKERS.—

"(A) IN GENERAL.—The Director of the Bureau of the Census shall, before the end of each fiscal year (beginning with fiscal year 1989), determine—

"(i) the number of special agricultural workers who have performed seasonal agricultural services in the United States at any time during the fiscal year, and

"(ii) for purposes of subsection (a)(5), the average number of man-days of such services certain of such workers have performed in the United States during the fiscal year.

"(B) BASIS FOR DETERMINATIONS.—Subject to subparagraph (C), such determinations shall be based on the certifications furnished to the Director under paragraph (2).

"(C) ADJUSTMENT FOR UNDERREPORTING AND DUPLICATE REPORTING.—The Director shall adjust the number otherwise determined so as to take into account the underreporting or duplicate reporting of special agricultural workers who have performed seasonal agricultural services at any time during the fiscal year. The Director shall periodically conduct appropriate surveys, of agricultural employers and others, to ascertain the extent of such underreporting or duplicate reporting.

"(c) ADMISSION OF ADDITIONAL SPECIAL AGRICULTURAL WORKERS.—

"(1) IN GENERAL.—Notwithstanding the numerical limitations under section 201 or the provisions of sections 202, 203, or 204, the number of aliens who may be issued visas or who otherwise may acquire the status of an alien lawfully admitted for permanent residence under this section in a fiscal year is equal to the shortage number (determined under subsection (a)) for the fiscal year, or, if less, the numerical limitation established under subsection (b)(1) for the fiscal year.

"(2) ALLOCATION OF VISAS.—The Attorney General shall, in consultation with the Secretary of State, provide such process as may be appropriate for aliens to petition for immigrant visas or to adjust status to become aliens lawfully admitted for permanent residence under this subsection. Such process shall provide special consideration for aliens who have been continuously residing in the United States since May 1, 1986. No alien may be issued a visa as an alien to be admitted under this subsection or may have the alien's status adjusted under

this subsection unless the alien has had a petition approved under this paragraph.

(d) RIGHTS OF ALIENS ADMITTED OR ADJUSTED UNDER THIS SECTION.—

"(1) IN GENERAL.—Except as otherwise provided in this subsection, an alien who acquires the status of an alien lawfully admitted for permanent residence under subsection (c), such status not having changed, is considered to be an alien lawfully admitted for permanent residence (as described in section 101(a)(20)).

"(2) EMPLOYMENT IN SEASONAL AGRICULTURAL SERVICES REQUIRED.—

"(A) FOR 2 YEARS TO AVOID DEPORTATION.—In order to meet the requirement of this paragraph (for purposes of section 241(a)(20)), an alien, who has obtained the status of an alien lawfully admitted for permanent residence under this section, must establish to the Attorney General that the alien has performed 60 man-days of seasonal agricultural services—

"(i) during the one-year period beginning on the date the alien obtained such status, and

"(ii) during the one-year period beginning one year after the date the alien obtained such status.

"(B) FOR 5 YEARS FOR NATURALIZATION.—Notwithstanding any provision in title III, an alien admitted under this section may not be naturalized as a citizen of the United States under that title unless the alien has performed 60 man-days of seasonal agricultural services in each of 5 fiscal years (not including any fiscal year before the fiscal year in which the alien was admitted under this section).

"(C) PROOF.—In meeting the requirements of subparagraphs (A) and (B), an alien may submit such documentation as may be submitted under section 210(b)(3).

"(D) ADJUSTMENT OF NUMBER OF MAN-DAYS REQUIRED.—The number of man-days specified in subparagraphs (A) and (B) are subject to adjustment under subsection (a)(7).

(e) TERMS OF EMPLOYMENT RESPECTING ALIENS ADMITTED UNDER THIS SECTION.—

"(1) EQUAL TRANSPORTATION FOR DOMESTIC WORKERS.—If a person employs an alien, who was admitted or whose status is adjusted under subsection (c), in the performance of seasonal agricultural services and provides transportation arrangements or assistance for such workers, the employer must provide the same transportation arrangements or assistance (generally comparable in expense and scope) for other individuals employed in the performance of seasonal agricultural services.

"(2) PROHIBITION OF FALSE INFORMATION BY CERTAIN EMPLOYERS.—A farm labor contractor, agricultural employer, or agricultural association who is an exempt person (as defined in paragraph (5)) shall not knowingly provide false or misleading information to an alien who was admitted or whose status was adjusted under subsection (c) concerning the terms, conditions, or existence of agricultural employment (described in subsection (a), (b), or (c) of section 301 of MASAWPA).

"(3) PROHIBITION OF DISCRIMINATION BY CERTAIN EMPLOYERS.—In the case of an exempt person and with respect to aliens who have been admitted or whose status has been adjusted under subsection (c), the provisions of section 505 of MASAWPA shall apply to any proceeding under or related to (and rights and protections afforded by) this section in the same manner as they apply to proceedings under or related to (and rights and protections afforded by) MASAWPA.

"(4) ENFORCEMENT.—If a person or entity—

"(A) fails to furnish a certificate required under subsection (b)(2) or furnishes false statement of a material fact in such a certificate,

"(B) violates paragraph (1) or (2), or

"(C) violates the provisions of section 505(a) of MASAWPA (as they apply under paragraph (3)),

the person or entity is subject to a civil money penalty under section 503 of MASAWPA in the same manner as if the person or entity had committed a violation of MASAWPA.

"(5) SPECIAL DEFINITIONS.—In this subsection:

"(A) MASAWPA.—The term 'MASAWPA' means the Migrant and Seasonal Agricultural Worker Protection Act (Public Law 97-470).

"(B) The term 'exempt person' means a person or entity who would be subject to the provisions of MASAWPA but for paragraph (1) or (2), or both, of section 4(a) of MASAWPA.

"(f) GENERAL DEFINITIONS.—In this section:

"(1) The term 'special agricultural worker' means an individual, regardless of present status, whose status was at any time adjusted under section 210 or who at any time was admitted or had the individual's status adjusted under subsection (c).

"(2) The term 'seasonal agricultural services' has the meaning given such term in section 210(g).

"(3) The term 'Director' refers to the Director of the Bureau of the Census."

(b) DEPORTATION OF CERTAIN WORKERS WHO FAIL TO PERFORM SEASONAL AGRICULTURAL SERVICES.—Section 241(a) (8 U.S.C. 1251(a)) is amended—

(1) by striking out "or" at the end of paragraph (18),

(2) by striking out the period at the end of paragraph (19) and inserting in lieu thereof "; or", and

(3) by adding at the end the following new paragraph:

"(20) obtains the status of an alien who becomes lawfully admitted for permanent residence under section 210A and fails to meet the requirement of section 210A(d)(3)(A) by the end of the applicable period."

(c) APPLICATION OF CERTAIN STATE ASSISTANCE PROVISIONS.—For purposes of section 204 of this Act (relating to State legalization assistance), the term "eligible legalized alien" includes an alien who becomes an alien lawfully admitted for permanent residence under section 210 or 210A of the Immigration and Nationality Act, but only until the end of the 5-year period beginning on the date the alien was first granted permanent resident status.

(d) CLERICAL AMENDMENT.—The table of contents is amended by inserting after the item relating to section 210 (as inserted by section 302) the following new item:

"Sec. 210A. Determination of agricultural labor shortages and admission of additional special agricultural workers."

SEC. 304. COMMISSION ON AGRICULTURAL WORKERS.

(a) ESTABLISHMENT AND COMPOSITION OF COMMISSION.—(1) There is established a Commission on Agricultural Workers (hereinafter in this section referred to as the "Commission"), to be composed of 12 members—

(A) six to be appointed by the President,

(B) three to be appointed by the Speaker of the House of Representatives, and

(C) three to be appointed by the President pro tempore of the Senate.

(2) In making appointments under paragraph (1)(A), the President shall consult—

(A) with the Attorney General in appointing two members,

(B) with the Secretary of Labor in appointing two members, and

(C) with the Secretary of Agriculture in appointing two members.

(3) A vacancy in the Commission shall be filled in the same manner in which the original appointment was made.

(4) Members shall be appointed to serve for the life of the Commission.

(b) FUNCTIONS OF COMMISSION.—(1) The Commission shall review the following:

(A) The impact of the special agricultural worker provisions on the wages and working conditions of domestic farmworkers, on the adequacy of the supply of agricultural labor, and on the ability of agricultural workers to organize.

(B) The extent to which aliens who have obtained lawful permanent resident status under the special agricultural worker provisions continue to perform seasonal agricultural services and the requirement that aliens who become special agricultural workers under section 210A of the Immigration and Nationality Act perform 60 man-days of seasonal agricultural services for certain periods in order to avoid deportation or to become naturalized.

(C) The impact of the legalization program and the employers' sanctions on the supply of agricultural labor.

(D) The extent to which the agricultural industry relies on the employment of a temporary workforce.

(E) The adequacy of the supply of agricultural labor in the United States and whether this supply needs to be further supplemented with foreign labor and the appropriateness of the numerical limitation on additional special agricultural workers imposed under section 210A(b) of the Immigration and Nationality Act.

(F) The extent of unemployment and underemployment of farmworkers who are United States citizens or aliens lawfully admitted for permanent residence.

(G) The extent to which the problems of agricultural employers in securing labor are related to the lack of modern labor-management techniques in agriculture.

The bill also includes language to protect both employers and prospective employees in the event cautious employers are unduly concerned by documentation presented to them. Specifically, the bill states that an employer will be deemed to have complied with the document examination requirement "if the document reasonably appears on its face to be genuine." In this event, the bill further provides that nothing in the legislation shall be construed as requiring the employer "to solicit the production of any other document or as requiring the individual (prospective employee) to produce such a document." In other words, if the verification procedure is followed, the language is intended to make clear that there is no requirement that an employer request additional documentation or that an employee produce additional documentation. The "reasonable man" standard is to be used in implementing this provision and the Committee wishes to emphasize that documents that reasonably appear to be genuine should be accepted by employers without requiring further investigation of those documents. In the event fraudulent documents are utilized, the bill does provide serious criminal penalties for such activities.

7. *Subcontractor provision.*—Some sanctions laws of foreign countries have proved to be ineffective because of loopholes which enable the use of subcontractors to avoid liability. The Committee intends to prevent any such loophole in the instant legislation. To accomplish this objective, the bill specifically provides that an employer "who uses a contract, subcontract, or exchange, entered into, renegotiated, or extended after the date of enactment . . . to obtain the labor of an alien in the United States knowing that the alien is an unauthorized (undocumented) alien" shall be considered to have hired the alien for employment.

8. *Social security validation system.*—While the bill allows for the use of existing identifiers as described under the "paperwork requirement" section above, it also requires the Attorney General to establish a "method to validate the social security account numbers" of persons applying for employment.

Specifically, the Attorney General is required to publish regulations on the establishment of such a system not later than 18 months after the enactment of this legislation. Further, not later than 6 months after final regulations are published, the Attorney General is required to implement this system.

Because of privacy concerns expressed by many Committee Members and many witnesses before the Committee, the bill specifically provides that nothing in the legislation "shall be construed to authorize, directly or indirectly, the issuance or use of national identifier cards or the establishment of a national identification card." This is intended to clearly express the Committee view that the verification procedures and the social security validation system are not intended to lead to the establishment or use of a national identification card.

Compliance with the social security validation system provides an employer with the same affirmative defense that is established with respect to compliance with the paperwork/verification requirements.

issue in *Anaya* was whether current law (U.S.C. 1324(a)(1)) would subject to criminal prosecution certain boat owners and crew members who willingly and knowingly transported undocumented Cuban nationals to the United States during the Mariel boatlift of 1980. Of crucial significance was the fact that the defendants in the case made no effort to land any undocumented Cubans surreptitiously or evasively, but instead brought them directly to immigration officers in Key West. Because existing law makes it a felony for anyone to "bring into" the United States an undocumented alien, the issue became the meaning of the term "bring into." The district court, sitting *en banc*, resolved this issue by holding that "bring into" is synonymous with "entering", and that since none of the undocumented Cubans ever "entered" the United States the indictments had to be dismissed.

On Appeal, the district court decision was affirmed, but for different reasons, *United States v. Zayas-Morales, supra*. The Court of Appeals focused on the defendants' state of mind and held that because the defendants lacked general criminal intent, (i.e., the intent to commit an illegal act), they could not be prosecuted under section 1324(a)(1).

The Committee is convinced that this gap in current law must be closed. Without the threat of criminal prosecution, there is no effective way to deter potential transporters from inundating U.S. ports of entry with undocumented aliens. As happened during the Mariel episode, the United States would be forced to expend extraordinary amounts of money and human resources in processing, monitoring, caring for and giving hearings to exorbitant numbers of people. Accordingly, the bill clarifies that a person who knowingly transports an undocumented alien to any place in the United States will be subject to criminal prosecution if that person knew the alien was undocumented or acted with wilful blindness concerning the alien's immigration status. Absent aggravating circumstances, the maximum penalty would be a fine of \$5,000 and up to 1 year in jail for each transaction. With aggravating circumstances (e.g., if the offense was committed for gain) the maximum penalty would be \$10,000 and 5 years imprisonment for each transaction.

Additionally, the bill increases the penalties for (1) knowingly bringing aliens, whether documented or not and whether an entry occurs or not, to any place in the United States other than designated ports of entry; (2) knowingly transporting within the United States undocumented aliens known to be such (or with wilful blindness to immigration status), and (3) knowingly harboring or concealing undocumented aliens anywhere in the United States. In each case, the maximum penalty would be a fine of \$10,000 and five years imprisonment for each alien involved.

Verification of alien status under certain programs

Section 121 of the bill requires States, beginning on October 1, 1988, to verify whether alien applicants for certain public assistance programs are in a lawful immigration status and thus eligible for participation in the programs. The programs covered are AFDC, Medicaid, Unemployment Compensation, Food Stamp program, Supplemental Security Income, Housing Assistance and Higher Education Assistance.

Congress, by law, has specifically disqualified undocumented and nonimmigrant aliens from certain of these programs. Regrettably, Federal, state and local agencies have not taken adequate steps to enforce these prohibitions. The INS believes that significant numbers of ineligible aliens are receiving assistance and that a verification procedure for alien applicants will result in a considerable cost saving for the Federal Government.

In order to comply with the requirements of this bill, a State must require all applicants to declare in writing under penalty of perjury whether they are citizens or nationals of the United States or aliens in a satisfactory immigration status. "Satisfactory immigration status" is defined as any immigration status which does not render an individual ineligible for benefits under the applicable program. A non-citizen or national of the United States must present to the State agency an alien registration document, other proof of immigration registration from the Immigration Service containing the file number of the alien, or other documents that constitute reasonable evidence indicating a satisfactory immigration status.

The bill further requires the State to then verify the declared immigration status of the non-citizen or national through an automated or other designated system, utilizing the applicants alien file or alien admission number given on the documentation. It also requires that any verification system designated by the INS shall protect the individuals privacy to the maximum degree possible. The designated system must be operative by October 1, 1987.

The verification provision in the bill had its genesis in the Systematic Alien Verification for Entitlements project, known as SAVE, implemented over the last two years by the INS in voluntary cooperation with the States. Three States were participating fully in the program and several other States had established pilot projects in certain cities. The Committee reviewed the implementation of this voluntary program and, while agreeing with the intent of the program, had several concerns. These concerns related to perceived inadequacies of the INS' data base and the potential misuse of the information available through the verification procedure.

For this reason, the bill contains crucial protections for both the individual's undergoing verification and the States implementing the procedure. The bill provides each individual undergoing verification a reasonable opportunity to submit evidence to the State showing a satisfactory immigration status. In addition, the State is prohibited from delaying, denying, reducing, or terminating the individual's benefits pending the submission of evidence showing satisfactory immigration status or pending the verification of that evidence by the INS. Upon denial of benefits the individual must be afforded the applicable fair hearing process. Finally, the Committee protects the States implementing the verification procedure from any liability for error in determining eligibility due to compliance with the requirements of this provision or the delay of the INS.

The bill prohibit the INS from using the verification procedure or the information obtained from it for administrative (non-criminal) immigration enforcement purposes. The Service has declared this to be the policy of the program from the beginning of the pro-

gram and the bill specifically reaffirms that policy. Most important, the Committee states unequivocally that the program shall be implemented in a non-discriminatory manner without regard to an individual's nationality, race, color, sex, or religion. The Committee intends to closely monitor the implementation of this provision.

Because the cost and relative impact of this program are uncertain, the Committee provides 100 percent reimbursement to the State to cover the costs of implementing the verification procedures.

ANTI-DISCRIMINATION

Numerous witnesses over the past three Congresses have expressed their deep concern that the imposition of employer sanctions will cause extensive employment discrimination against Hispanic-Americans and other minority group members. These witnesses are genuinely concerned that employers, faced with the possibility of civil and criminal penalties, will be extremely reluctant to hire persons because of their linguistic or physical characteristics.

Representative Robert Garcia testified that "as a shorthand for a fair identification process, employers would turn away those who appear 'foreign', whether by name, race or accent" (Joint Hearing Before the House Subcommittee on Immigration, Refugees, and International Law and the Senate Subcommittee on Immigration and Refugee Policy, Anti-Discrimination Provision of H.R. 3080, Serial No. 35, p. 111; hereinafter cited as 1985 Joint Hearings).

The Committee does not share the view that wholesale employment discrimination will necessarily result from the enactment of sanctions and notes that GAO's recent study of sanctions laws of other countries did not document such discriminatory impacts. Nevertheless, the Committee does believe that every effort must be taken to minimize the potentiality of discrimination and that a mechanism to remedy any discrimination that does occur must be a part of this legislation.

In this regard, the bill does provide substantial protections against discrimination in the form of a uniform verification process for all new hires and extensive monitoring and reporting requirements on the discrimination issue. It also established a Special Counsel in the Department of Justice, appointed by the President, by and with the advice and consent of the Senate, to investigate charges of employment discrimination based on national origin (in certain cases) or citizenship status.

Regarding the need for an anti-discrimination provision, Richard Keatings, Chairman of the ABA's Coordinating Committee on Immigration Law testified as follows:

Any perceived or likely ill-effects, especially where they concern discrimination . . . in the workplace must be protected against even if such feared results never occur . . . So anti-discrimination protections are essential to this bill if only to protect against a result we all hope will never occur . . . There is no reason to avoid instituting anti-discrimination machinery if one is convinced it will never be needed. There is every reason to insist on the inclusion of

bility for legalization shall not be deported until they have had a chance to file for legalization, but in no case later than 30 days after the start of the period for accepting applications. Aliens who are given an order to show cause why they should not be deported and who wish to be legalized must also apply within 30 days of the beginning of the legalization application period if the order is issued prior to that date, and within 30 days of the issuance of the show cause order if it falls within the one year period.

The bill provides for limited administrative and judicial review of denials of applications for legalization. The Attorney General is to establish a single level of administrative appellate review for reconsideration of denied cases. When the administrative review is exhausted and also yields a negative decision, and when the applicant is in a deportation proceeding (but not an exclusion proceeding), the applicant can appeal a negative decision within the context of judicial review of a deportation order.

Prohibition on receipt of public assistance

A person who is legalized under the program, or under the change in the registry date, discussed below, is not eligible for Federal financial assistance, Medicaid or food stamps for a five-year period beginning after he or she becomes a temporary resident alien, with limited exceptions.

The exceptions are that the Attorney General may, through regulations developed in consultation with the Secretary of Health and Human Services, allow federal assistance to recently legalized aliens because of age, blindness, disability, or medical conditions that require treatment in the interest of public health or because of serious illness or injury. This is an exception, not an entitlement. The Committee intends that the relevant eligibility and needs requirements under the applicable programs shall apply to the newly legalized aliens. The Committee emphasizes that these limited exceptions are not intended to be an indirect method of affording newly legalized aliens automatic access to Supplemental Security Income, Medicaid, or Medicare. The bill permits State and local governments also to limit benefits to newly legalized aliens.

The Committee believes that limited Federal medical benefits can be provided to newly legalized aliens without such benefits leading indirectly to complete access of Medicaid programs.

The Committee takes exception to the position of the Department of Health and Human Services (HHS) that a limited emergency medical program cannot be developed because it would be, in HHS' view, "disruptive, expensive, and difficult to target." The Committee expects HHS to develop and implement a limited medical benefits program in accordance with the statutory mandate set forth in this legislation.

The limitations on benefits do not apply to newly legalized aliens who prior to legalization, were Cuban/Haitian entrants or to certain educational and health programs.

The Committee is convinced that the public benefit restrictions imposed upon newly legalized aliens are constitutionally permissible. The Committee has reviewed the Supreme Court decision in *Mathews v. Diaz*, 426 U.S. 67 (1976) and is convinced that the restrictions contained in the Committee Amendment are authorized

by that decision. In that case a permanent resident alien challenged that portion of the Medicare law which denies eligibility to permanent resident aliens unless they have resided in the United States for five years. In upholding the statute against the plaintiff's due process challenge, the Court stated:

In particular, the fact that Congress has provided some welfare benefits for citizens does not require it to provide like benefits for *all aliens*. * * * The decision to share that bounty with our guests may take into account the character of the relationship between the alien and his country: Congress may decide that as the alien's tie grows stronger, so does the strength of his claim to an equal share of that munificence. *Id.* at 80 (emphasis in original).

Likewise, the Committee believes that the provision of the bill that authorizes the states to deny state welfare benefits to newly legalized aliens is constitutionally sound. In this regard, the Committee notes that such restrictions would be wholly consistent with Federal policy. *CF. Plyler v. Doe*, 102 S. Ct. 2382 (1982) (state statute denying free public education to undocumented alien children held unconstitutional for failure to comport with Federal policy). The Committee further notes that this provision, and the provision restricting access to Federal benefits have been reviewed by the Office of Legal Counsel in the Department of Justice and found to be "constitutionally sound." (See testimony of Attorney General Smith, 1983 Immigration Subcommittee Hearings, p. 1459.)

CUBAN-HAITIAN ADJUSTMENT

During the late 1970's and early 1980's, a number of Cubans and Haitians fled the oppressive conditions in their home countries and arrived in the United States without entrance documents. This situation reached its peak in 1980 when over 100,000 Cubans and approximately 25,000 Haitians arrived. Recognizing the extreme hardship that would be involved if these individuals were deported, the Carter Administration paroled these individuals into the United States, giving them the designation "Cuban-Haitian Entrants." Since that time, the Reagan Administration has continued the parole policy. The result is that these individuals remain in the United States.

During the 98th Congress, both the House and the Senate, recognizing the inappropriateness of continuing parole for a group of people who are permanently residing in the United States under color of law and realizing that the interests of the United States would best be served if Cuban-Haitian Entrants were allowed to apply for lawful permanent residency in the United States, considered remedial legislation. Though immigration reform legislation granting that relief (H.R. 1510 and S. 529) was approved by both the House and Senate, the 98th Congress ended before the legislation could be enacted into law. In addition, a second House bill, H.R. 4853, introduced by Chairman Rodino and containing a Cuban-Haitian provision identical to the one approved by the House in the context of H.R. 1510, was unanimously passed by the House of Representatives on October 4, 1984. No separate compan-

the President to submit a comprehensive report on general legal admissions three years after enactment of this bill and every three years after.

The report, among other matters, will include the number and classifications of aliens admitted; an estimate of the number who entered without visas and became deportable during the period and a description of the impact of admissions on all facets of American life, i.e. economic, social, educational, environmental, etc.

The report is to conclude with recommendations on changes in numerical limitations on immigration or on other policies bearing on the admission and entry of aliens.

Congress has plenary jurisdiction over immigration matters. The policies on immigration are carried out by four separate U.S. agencies: refugees are the responsibility of the Departments of State, Justice and Health and Human Services; immigrants are the responsibility at various times and in various stages of the Immigration and Naturalization Service in the Department of Justice, the Department of State for visa issuance and allocation and the Department of Labor for certification of employment conditions for immigration purposes.

Because of this diversification and the importance attached by each to its responsibilities, any attempt to establish meaningful flexibility in this country's immigration program is difficult.

At various times proposals have been forthcoming on the establishment of a permanent governmental body to institute a flexible immigration law. In 1953, the Truman Commission Report proposed an immigration board as an independent agency separate from the Department of Justice and State to advise on immigration ceilings and quotas consistent with conditions in the United States.

In 1963, under President Kennedy, both the House and Senate introduced legislation to establish a permanent immigration board for the same purpose but again with no results.

As late as 1980, the Select Commission on Immigration and Refugee Policy framed a proposal for an independent regulatory immigration and refugee council. The council was to recommend 3 to 5 year targets on annual immigration ceilings after having made in-depth studies. These recommendations were never translated in law.

H.R. 3810 is legislation designed to present solutions to the illegal immigration problem presently facing the nation. Its enactment may produce unforeseeable impacts on legal immigration.

The Presidential reports cited in this section will enable the executive agencies and the Congress to review and study our immigration and refugee programs and to consider possible changes to them with the benefit of reliable and detailed data.

Reports on unauthorized alien employment and discrimination in employment

H.R. 3810 makes it unlawful for a person or other entity after enactment to hire, recruit or refer for a fee for employment any alien who is not legally in the United States. In conjunction with this prohibition, it is provided that an employment verification system be established to enable enforcement of the employment sanctions. Specifically, the legislation provides for the establish-

ment of a Social Security Account Number Validation System which is to be established by the Attorney General, in cooperation with the Secretaries of Labor and Health and Human Services. This validation system is required to be operational within eighteen months after enactment.

Sec. 402 of the bill requires the President to provide the Committees of the Judiciary of the House and Senate every six months with an analysis of the adequacy of the employment verification system. In addition, he is to report on the impact sanctions are having on the employment, wages and working conditions of U.S. workers. He is also to report on the number of aliens entering the United States illegally, as well as the number of overstays who have violated the terms and conditions of their visas.

In processing this legislation, a number of concerns were raised that employer's sanctions would result in employment discrimination against both citizens and permanent resident aliens.

H.R. 3810 has extensive protection against unfair immigration-related employment practices. The President is required under this legislation to report on the impact of the employer sanctions provisions on discrimination against minority groups.

Considerable discussion was generated during the processing of H.R. 3810 to the effect the employer sanctions provisions were placing an undue burden on employers in requiring them to do the paperwork and keep records on employees in order to comply with the pertinent sections of this bill.

The President is requested to submit the last reports on the eighteenth, thirty-sixth and fifty-fourth months after the date of enactment.

These reports will provide the Congress with significant, empirical data in reviewing the impact of sanctions and to determine whether any future legislation on this subject is necessary.

Section 402 also requires the Civil Rights Commission to monitor and report to the Committees on the Judiciary of the House and Senate on the implementation and enforcement of the provisions of employers sanction and whether there has been any unlawful discrimination by race or nationality in the implementation of these provisions.

The U.S. Commission on Civil Rights, an agency established by Congress in 1957, is generally charged with investigating complaints of discrimination by reason of race, color, religion, sex, age, handicap or national origin in federal laws and policies. The Commission also serves as a clearing-house for information in respect to all types of discrimination.

Reports from the Commission are required to be submitted on the eighteenth month after enactment, as well as the thirty-sixth and fifty-fourth months.

Reports on H-2A Program

Section 403 of the bill requires the President to furnish a report not later than two years after the date of enactment and every two years thereafter on the implementation of the temporary agricultural worker (H-2A) program.

The report is to include (1) the number of workers employed in the program each year; (2) the compliance with the terms and con-

thorizes an appropriation of \$35 million to be used in accordance with the contingency plan.

VERIFICATION OF ALIEN STATUS UNDER CERTAIN PROGRAMS

Sec. 121.—Requires the States to verify the immigration status of aliens applying under certain public assistance programs. Provides an opportunity for the alien applicant to submit evidence as to immigration status without denial or termination of benefits until the evidence has been verified. Provides that the States shall not be liable for the consequences of such verification. Provides 100% reimbursement to the States for implementing the verification system. Prohibits use of the verification system for certain enforcement purposes and prohibits discriminatory implementation of the verification system.

LEGALIZATION

Sec. 201.—Creates a new Section 245A.

New Sec. 245A(a).—Requires the Attorney General to grant temporary resident status to aliens who apply within the 18-month application period or within 30 days of the issuance of an order to show cause and who meet the eligibility requirements of this section. Requires that the alien show continuous residence in the United States in an unlawful status (including Cuban/Haitian entrant status) since before January 1, 1982 and general admissibility as an immigrant. In addition, the alien must establish that he or she has not been convicted of a felony or of three or more misdemeanors committed in the United States, has not assisted in the persecution of any person and has registered under the Military Selected Service Act if so required.

New Sec. 245A(b).—Requires the Attorney General to grant permanent resident status to temporary resident aliens who apply for adjustment during the 12-month application period beginning one year after the grant of temporary residence and who meet the eligibility requirements of this section. Requires that the temporary resident demonstrate minimal understanding of English and knowledge of U.S. history and government (or pursuit of such understanding and knowledge through a course of study) and general admissibility as an immigrant. Provides that the temporary resident status of aliens who do not apply for permanent residence shall be revoked. Authorizes brief and casual trips abroad and employment during temporary resident status.

New Sec. 245A(c).—Authorizes the filing of applications for adjustment to lawful status with the Attorney General or designated voluntary, state, local, community organizations and individuals. Provides for the confidential treatment of records and files relating to such application and establishes a penalty for permitting unlawful access to such information. Establishes a criminal penalty for fraudulent application.

New Sec. 245A(d).—Specifies that the numerical limitations on immigration shall not apply to this section and waives certain documentary grounds of exclusion. Permits the Attorney General to waive additional grounds of exclusion (except criminal, national security, and certain drug grounds) for humanitarian purposes, to

ensure family unity, or when it is otherwise in the national interest.

New Sec. 245A(e).—Authorizes a temporary stay of deportation and work authorization for aliens apprehended prior to the application period who can establish a non-frivolous case of eligibility for adjustment under this section.

New Sec. 245A(f).—Provides for a single level of administrative appellate review of a denial of an application for adjustment of status. Permits judicial review of such denial only within the context of the review of an order of deportation.

New Sec. 245A(g).—Requires the Attorney General to issue such regulations as may be necessary to carry out this section, including a definition of the term “residing continuously.”

New Sec. 245A(h).—Disqualifies a newly legalized alien from receipt of certain programs of federal public assistance for a period of five years from the date the alien received temporary resident status. Permits States and local governments to impose similar restrictions on financial and medical assistance furnished at the State and local level. Further provides that the disqualification will not apply to (1) Cuban/Haitian entrants, (2) aliens who are aged, blind, or disabled, and (3) certain medical and education programs.

New Sec. 245A(i).—Requires the Attorney General, in cooperation with qualified agencies and organizations, to widely disseminate information on the program of legalization under this section.

CUBAN-HAITIAN ADJUSTMENT

Sec. 202—Authorizes the Attorney General to grant permanent resident status to certain Cubans and Haitians who are currently in “Entrant” status or who established a record with the INS prior to January 1, 1982 and who have resided continuously in the United States since before January 1, 1982. Provides that an adjustment of status under this section shall not reduce the overall number of available immigrant visas.

Sec. 203 to — UPDATING REGISTRY DATE

Sec. 203—Amends Section 1259 of title 8 of the United States Code by updating the date for legal registry from June 30, 1948, to January 1, 1976.

STATE LEGALIZATION ASSISTANCE

Sec. 204(a)—Authorizes appropriations for fiscal years 1987 through 1991 in such sums as may be necessary to carry out State legalization assistance under this section.

Sec. 204(b)—Requires, subject to available appropriations, the Secretary of Health and Human Services to provide the State 100 percent reimbursement for costs of State and local programs of public assistance. Limits State and local programs covered to those programs (1) providing cash, medical or other assistance designed to meet the basic subsistence or health needs of individuals or required for the public health, (2) generally available to all needy residents of the State or locality, and (3) funded by the State or local government.

Sec. 204(c)—Requires, subject to available appropriations, the Secretary of Education to assist to local educational agencies in meeting the costs of educating newly legalized aliens.

Sec. 204(d)—Requires the Secretaries of Health and Human Service and Education to consult with State and local governments in establishing regulations under this section.

TEMPORARY H-2A WORKERS

Sec. 301(a)—Creates a separate (H-2A) classification for nonimmigrant workers coming to the United States to perform agricultural labor or services (as defined by the Secretary of Labor) of a temporary or seasonal nature.

Sec. 301(b)—Provides for consultation by the Attorney General with the Department of Labor and Agriculture on bringing H-2A workers into the United States.

Sec. 301(c)(1)—Creates a new Section 216.

New Sec. 216(a)—Authorizes the admission of temporary H-2A workers only when the employers has petitioned the Secretary of Labor for a certification that (A) there are not sufficient workers who are able, willing, and qualified, and who will be available at the time and place needed, to perform the labor or services involved in the petition, and (B) the employment of the alien in the labor or services will not adversely affect the wages and working conditions of workers in the United States similarly employed. Allows the Secretary of Labor to charge a fee to issue the certification.

New Sec. 216(b)—Prohibits the Secretary of Labor from issuing a certification if the standards for the certification are not met or if (1) there is a strike or lockout, (2) the employer substantially violated in the previous 2 years a material term or condition of a previous certification, (3) worker's compensation insurance is not provided, and (4) the employer has not made positive recruitment efforts (in addition to circulation of the job offer and until the H-2A workers depart for work) within a multi-state region of traditional or expected labor supply.

New Sec. 216(c)—Provides special rules for treatment of H-2A applications. (1) The application need not be filed more than 60 days before the date of need. (2) The employer must be notified within 7 days of any reason for disapproval of the application (other than the failure to have sufficient domestic workers). (3) The Secretary of Labor must approve the application, at least 20 days before the date of need, if the conditions for approval are met and the employer does not actually have, or has not been provided with referrals of qualified individuals (based on the normal and accepted qualifications by non-H-2A employers for comparable occupations and crops). (4) For 3 years, the labor certifications require the employer (other than a small employer who is not associated with other H-2A employers) to provide employment to qualified U.S. workers who apply until the end of 50 percent of the H-2A worker's contract work period. Six months before the end of the 3-year period, the Secretary of Labor is required to consider the advisability of continuing this requirement and issue findings and regulations which (in the absence of Federal legislation) are published 3

consideration of this subject, we must provide a legislative reform that will improve the administration of our immigration laws.

U.S. DEPARTMENT OF JUSTICE,
OFFICE OF LEGISLATIVE AND INTERGOVERNMENTAL AFFAIRS,
Washington, DC, June 4, 1986.

Hon. PETER W. RODINO, Jr.,
Chairman, Committee on the Judiciary,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: This responds to your request for the Department of Justice's views on H.R. 3810, the "immigration control and Legalization Amendments Act of 1985." The Department supports enactment of this legislation if certain major and several minor revisions are made.

This Administration has consistently supported immigration reform, and the pressing need for legislation remains. We are pleased that you and Congressman Mazzoli are sponsoring H.R. 3810. We look forward to working with your Committee.

EMPLOYMENT OF UNAUTHORIZED ALIENS

Section 101

Section 101 of the bill amends present Section 274(A) of the Immigration and Nationality Act (the Act) to provide penalties, also known as "sanctions", for employers who commit two types of offenses: (1) knowingly hiring an alien who is not authorized to work; and (2) failing to comply with the requirements of the Employment Verification System.

Employment verification

An employer must verify that each applicant for employment ("applicant") has established his or her authorization to work in the United States, including examining an applicant's identifying documentation and employment authorization. The applicant must also attest that he is a citizen or national of the United States, an alien lawfully admitted for permanent residence, or an alien authorized by the Attorney General to be employed. The employer must retain these records for a period of time specified by the Attorney General. Good-faith compliance with these requirements is an affirmative defense to a charge that the employer has knowingly employed an unauthorized alien.

Telephone verification

Proposed section 274A(b)(7) requires that the Attorney General, in cooperation with the secretaries of Labor and Health and Human Services, establish a method to validate the social security account numbers of individuals applying to be hired, recruited or referred for employment in the U.S.

Hearing process

Proposed section 274A(d)(4) provides for a hearing, before an administrative law judge, to determine whether a violation has occurred. An employer who requests a hearing may, within 60 days of an adverse decision, file a petition for review with the appropri-

**VERIFICATION OF IMMIGRATION STATUS OF ALIENS APPLYING FOR
BENEFITS UNDER CERTAIN PROGRAMS**

Section 121

Section 121 establishes a verification requirement for persons applying for benefits under the AFDC, Medicaid, Unemployment Compensation and Food Stamp Programs. Each applicant or recipient must attest in writing to their U.S. citizenship, or provide proof of immigration registration if the person is not a citizen. The state must verify an alien's status through the INS so that the agency administering the program may determine the alien's eligibility for the benefits.

In addition, this section provides a definition of "Permanently Residing in the United States Under Color of Law" (PRUCOL) for purposes of the Social Security Act, the Unemployment Tax Act and Section 484 of the Higher Education Act of 1965. Basically, the definition limits "PRUCOL" to refugees, asylees, persons granted withholding of deportation, registrants under Section 249, aliens paroled into the United States, and persons granted deferred action.

Comments

We support the Committee's efforts to develop an alien verification program. The Administration is in the process of developing a cost-effective program to implement the alien verification concept, and will forward amending language to the Committee shortly.

LEGALIZATION STATUS

Section 201

Section 201 legalizes the status of certain aliens unlawfully in the United States. In general, this section applies to an alien who entered the United States prior to January 1, 1982, and who has continuously resided in the U.S. in any unlawful status since January 1, 1982. The alien must also establish continuous physical presence here since enactment. An alien shall not be considered to have failed to maintain continuous physical presence in the United States if the absence has been brief, casual, and innocent. In the case of a nonimmigrant, the alien must show that his period of authorized stay expired before January 1, 1982, through the passage of time or that the alien's unlawful status was known to the Government on that date.

Although eligibility is specifically confined to aliens who have entered the United States, an exception is made for "Cuban/Haitian Entrants (Status Pending)" described in paragraph (1), or (2)(a), of Section 501(e) of Public Law 96-422. Persons in this category are deemed to have entered the United States for purposes of this section.

The applicant must also show that he is admissible as an immigrant with certain grounds of inadmissibility specifically waived, and others which may be waived in the discretion of the Attorney General. The exclusion from eligibility in the case of an individual likely to become a public charge may be disregarded in the case of an alien with a U.S. work history that evidences self-support with-

first two years and \$600 million in each of the next two years—to help States meet the costs of such assistance.

H-2A WORKERS

Section 301

Section 301 establishes a nonimmigrant classification for temporary agricultural workers (H-2A), and adopts a new program for admitting them. A labor certification shall not be issued under certain circumstances, *e.g.*, a strike or lockout during a labor dispute; employer violation of a previous labor certification; or employer failure to provide workers' compensation, if not otherwise covered by State law.

Rules for consideration of applications

Applications must be filed with the Secretary of Labor not more than sixty days before an employer requires the services of a temporary worker. The employer must be notified within seven days of the filing if the application is deficient. The certification must be made not later than twenty days before the employer requires the services of a temporary worker. The certification remains effective only if the employer continues to accept for employment, qualified individuals who apply or are referred to him until the date when the H-2A workers depart to work for the employer. The employer would be required to offer housing. An H-2A petition may also be filed by an agricultural association. When a petition is denied because there are sufficient workers who are able, willing and qualified, or because employment of the temporary worker will adversely affect the wages and working conditions of similarly employed U.S. workers, there is an expedited administrative appeal. In administrative appeal circumstances, the Secretary of Labor must make a new determination within 72 hours of a request. The employer has the burden of proof to establish that an eligible U.S. worker is not able, willing, or qualified to perform the requested labor.

The temporary worker cannot be admitted for longer than that determined by regulation. He may also not be admitted if in the previous five-year period he had violated the terms of his admission.

Funding

Section 301 also authorizes the appropriation, for fiscal year 1987 and after, of 10 million dollars, to recruit domestic workers for temporary services, and to monitor the H-2A program. The Secretary of Labor is authorized to impose appropriate penalties and seek appropriate relief to ensure an employer's compliance with the terms of the employment. Such sums of monies are authorized to be appropriated to the Secretary as may be appropriate to make H-2A determinations and certifications. The Secretary may require payment of a fee to recover reasonable costs of processing certifications.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the Committee estimates that this bill will not have a significant inflationary effect on prices and costs in the operation of the national economy.

ESTIMATE OF COST

The Committee wishes to emphasize that the long term economic benefits of this legislation will be substantial. By reducing illegal immigration through employer sanctions, it is expected that INS' enforcement costs will, in time, be reduced, a positive impact on our balance of payments will be achieved and increased tax revenues will be obtained as the result of the legislation program. Most important, job opportunities will be made available for millions of unemployed Americans and there will be a concomitant decrease in expenditures (unemployment, public assistance, etc.) made in behalf of such workers.

Pursuant to clause 7, rule XIII of the Rules of the House of Representatives, the Committee states that it generally concurs with the cost estimates submitted by the Congressional Budget Office and set forth below. The Committee wishes to note, however, that, although incalculable, there are substantial monetary and societal costs attributable to illegal immigration, and it is clear that these costs will diminish due to this legislation.

BUDGETARY INFORMATION

Clause 2(1)(3)(B) of rule XI of the Rules of the House of Representatives is inapplicable because the instant legislation does not provide new budget authority. Pursuant to Clause 2(1)(3)(C) of rule XI, the following estimate was prepared by the Congressional Budget Office and submitted to the Committee:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 15, 1986.

Hon. PETER W. RODINO, Jr.,
Chairman, Committee on the Judiciary, House of Representatives,
Rayburn House Office Building, Washington, DC

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for H.R. 3810, the Immigration Control and Legislation Amendment Act of 1986.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,
Sincerely,

RUDOLPH G. PENNER.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 3810.
2. Bill title: Immigration Control and Legalization Amendments Act of 1986.

Naturalization Service and the National Labor Relations Board, CBO expects this process to cost \$2 million in 1987 and 1988 and \$3 million in later years. The bill does not, however, authorize appropriations for this activity. Also required would be a system to validate the Social Security account numbers of all individuals employed in the United States. Employers would be required to submit each account number and receive a validation code. CBO estimates that approximately 80 million numbers would be submitted for validation each year. Based on information from the Social Security Administration, CBO estimates that this system would cost about \$130 million each year, beginning in 1988, with slightly higher costs in the first year. Both of these estimates are highly uncertain.

Title I authorizes an appropriation of \$35 million for an immigration emergency fund, to be used for increased enforcement of the nation's immigration laws and for providing assistance to states and localities facing major immigration problems. CBO does not show an increase in outlays as a result of this fund, because spending is prohibited unless the President declares an immigration emergency, and it is impossible to predict when, or whether, such a declaration would be made.

The bill requires that the immigration status of aliens applying for a number of federal benefit programs be verified with the INS beginning no later than October 1, 1988. All state costs would be fully reimbursed by the federal government. CBO estimates that this provision would have no significant budgetary effect in 1987 or in 1988, would reduce outlays by \$25 million in 1989, and by \$20 million a year thereafter. These savings are very uncertain. The only tests of the verification system have been for the Unemployment Compensation program in a few states, where savings were found to be modest. The CBO estimate for the Unemployment Compensation program is based on these test results. Savings for the Aid to Families with Dependent Children, Medicaid, and Food Stamp programs are based on the number of cases found to be in error because of alien status, as reported in the quality control data systems. This estimation procedure underestimates savings. Costs are based on information provided by the INS and assume in most cases a statewide system of checking. These costs are underestimated because some states with county-run programs would have higher costs. Also, there is expected to be considerable adjudication, because the INS data are out-of-date and incomplete; this cost cannot be estimated.

The following table summarizes the costs of Title I.

ESTIMATED BUDGET IMPACT—CONTROL OF ILLEGAL IMMIGRATION (FUNCTIONS 550, 600, AND 750)

[By fiscal year, in millions of dollars]

	1986	1987	1988	1989	1990	1991
Authorizations:						
Immigration and Naturalization Service ¹	422	419	.....	.....	.....	.....
Executive Office of Immigration Review ¹	12	15	.....	.....	.....	.....
Immigration emergencies		35	.....	.....	.....	.....
Status verification ²		(³)	(³)	-15	-10	-10
Other estimated costs ⁴		2	351	317	311	286

ESTIMATED BUDGET IMPACT—CONTROL OF ILLEGAL IMMIGRATION (FUNCTIONS 550, 600, AND 750)—Continued

[By fiscal year, in millions of dollars]

	1986	1987	1988	1989	1990	1991
Total estimated authorizations.....	434	471	351	302	301	276
Estimated outlays.....		371	364	297	292	270

¹ It is assumed that enactment of this bill will not allow time for funds to be appropriated in fiscal year 1986; therefore, no outlays are shown for the 1986 authorizations.

² The bill authorizes such sums as may be necessary for the INS. This estimate also includes CBO's estimate of costs and savings in functions 550 and 600.

³ Less than \$0.5 million.

⁴ This amount reflects estimated costs for which no authorizations are provided in the bill. These costs are largely for INS enforcement and processing activities after 1987, and for the required system for validating an individual's Social Security number.

Legalization (Functions 550, 570, 600, and 650).—By legalizing some unauthorized aliens currently in the United States, Title II would increase federal outlays in functions 550 (Health, including Medicaid), 570 (Medicare), 600 (Income Security), and 650 (Social Security). First, the provisions that legalize unauthorized aliens would entitle the aliens to receive benefits after five years from a number of federal assistance programs. Such programs as Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), Medicaid, and Food Stamps now require recipients to be citizens or have resident status. Because the provisions of the bill preclude most aliens granted resident status from receiving any program of federal financial assistance based on "financial need," Medicaid, and Food Stamps for a period of five years, federal outlays for these programs generally do not begin until fiscal year 1992, beyond our estimating period. An exception is made in the bill for the aged, blind, and disabled and for medical assistance provided to children under 18 years of age, pregnant women, and those in need of emergency services. Hence, the cost estimate does show increased federal outlays for SSI, Medicaid, and Food Stamps beginning in fiscal year 1987. In addition, in other programs that are not based on "financial need," such as Disability Insurance (DI), some legalized aliens who would not have collected benefits would now be expected to do so.

Second, Title II provides an authorization for the appropriation of such sums as may be necessary in fiscal years 1987 through 1991 to reimburse states for 100 percent of the costs of public assistance to eligible legalized aliens. Aliens granted resident status are eligible for five years. The bill also authorizes payments over the same five-year period to state education agencies to assist in providing educational services for the legalized alien children in elementary and secondary schools.

Added federal program outlays as a result of legalizing unauthorized aliens under Title II of the bill are shown in the table below. These added outlays are estimated to be \$8 million, \$272 million, \$1,143 million, \$1,646 million, and \$1,777 million in fiscal years 1987 through 1991, respectively.

This estimate is very uncertain, particularly because of the three factors discussed below. First, this estimate includes federal outlays for the grants to states that are large enough to cover the full estimated costs to states for public assistance to the legalized aliens and education services for the legalized alien children. Less than

the full costs, however, might be appropriated. Second, this estimate depends importantly on the number of unauthorized aliens in the United States, for which little hard evidence exists. It has been generally accepted that there were 3 million to 6 million unauthorized aliens in the United States in the late 1970s. The CBO estimate uses 4.5 million aliens in 1977, the midpoint of the range. Even less is known about how the numbers of unauthorized aliens in the United States may have changed in recent years, although anecdotal evidence indicates there has been some net inflow. Based on conversations with persons knowledgeable about the unauthorized alien population, CBO assumes a net increase of 150,000 in each year beginning in 1980. In 1986, then, CBO assumes that there are 5.6 million unauthorized aliens in the United States.

Of the 5.6 million unauthorized aliens, CBO estimates that 40 percent have resided continuously in the United States since January 1, 1982, making them eligible for legalization under this bill. This figure is based on percentages from Immigration and Naturalization Service (INS) studies, which have been adjusted upward to reflect the assumption that some unauthorized aliens are aware of the possibility of legalization because of legislative activity in recent years. Among those eligible, we assume—again based on conversations with experts—that approximately 60 percent would apply for and be granted resident status. The resulting number of unauthorized aliens who would be granted resident status is estimated to be 1.4 million.

Finally, the number of legalized aliens who would qualify for government assistance programs is uncertain. In large part, this reflects a lack of data on the economic and demographic characteristics of unauthorized aliens—for example, their employment status and wages or their age and marital status. In developing the estimates of numbers of legalized aliens who would receive benefits from government programs, CBO assumes that the unauthorized aliens would have to show at the time of their application for residency that they had not been nor would they be likely to be “public charges,” as specified in Section 212 of the Immigration and Nationality Act. However, the bill would allow resident status to an unemployed alien if that alien could demonstrate a history of employment without reliance on public cash assistance. Thus, at the time the aliens would become residents, most would presumably be working. Over time, however, they could be expected to resemble the U.S. population as to receipt of benefits from entitlement programs. By 1990, CBO assumes that the percentage of unauthorized aliens receiving government benefits would resemble that of the U.S. population for similar age, sex, ethnic origin, and income groupings. In the interim years, CBO assumes that a growing fraction of potential eligibles would in fact receive benefits: 5 percent in 1987, 30 percent in 1988, and 75 percent in 1989.

In addition to the general basis of these estimates, each individual program estimate entailed specific procedures and assumptions. The details for each program are discussed below.

The SSI program provides benefits to aged, blind, and disabled persons. Benefit levels are set by the federal government, which pays the full cost of the program, although states may supplement federal benefits and most do. Under this bill, legalized aliens would

be eligible to receive SSI upon confirmation of residency status. Costs to the federal government are estimated to rise from an insignificant amount in 1987 to \$116 million in 1991. CBO's cost estimate is based on a reciprocity rate of 0.90 percent of the alien population for the aged and 0.94 percent for the blind and disabled. The reciprocity rate for the aged is based on Census data which show 1.80 percent of illegal aliens to be aged, an assumed income eligibility of 100 percent, and a participation rate for the eligible of 50 percent. The reciprocity rate for the blind and disabled is based on the current reciprocity rate for the population. The aliens are estimated to receive the full SSI basic benefit, or \$4,131 in 1987.

Food stamps are issued to eligible low-income households. Benefits (and approximately one-half of state administrative expenses) are funded by the Federal Government. As with AFDC, most legalized aliens could not receive food stamps until 1992, although legalized aliens who received SSI could also receive food stamps. Food stamp costs are estimated to be insignificant in 1987, rising to \$6 million in 1991. This figure is based on the estimated number of aliens added to the SSI rolls and a food stamp participation rate of 45 percent, the estimated current rate of SSI recipients. Average annual benefits per person in 1987 are estimated to be \$444.

The Unemployment Compensation program provides weekly cash benefits to workers who are involuntarily unemployed and who have had at least a moderate amount of work experience during a one-year period prior to losing their jobs. Under this bill, Unemployment Compensation cost for newly legalized alien workers are estimated to rise from \$3 million in 1987 to \$115 million in 1991. This estimate is based on several assumptions for newly legalized alien workers. Consistent with recent labor force data on young Hispanics, CBO assumes that 80 percent of these workers would participate in the labor force, a higher rate than the average of the U.S. population. Because most probably work in service industries, which are less prone to cyclical unemployment, and because even low-wage jobs in this country probably appear attractive when compared to those in the country of origin, CBO assumes that the newly-legalized population would have unemployment rates one percentage point lower than those in effect for the rest of the U.S. population. Further, assuming, as some evidence indicates, that these individuals' earnings are about 60 percent of those of comparable U.S. production or nonsupervisory workers (and assuming a 50 percent wage replacement rate), CBO estimates that the average weekly benefit amount for these workers would be about \$97 in 1987, one-fourth lower than that for the remainder of the population.

The Disability Insurance (DI) program covers persons who are totally disabled (whose disability is expected to last at least 12 months or result in death) and who have sufficient work histories in covered employment. Costs in DI of the legalized aliens are estimated to rise from an insignificant amount in 1987 to \$54 million in 1991. Because the evidence indicates that unauthorized aliens are relatively young on average, they would be less likely to be disabled than the U.S. population as a whole. Also, because they have been in the United States for relatively short periods of time, they might not qualify for DI, which requires for most workers covered

earnings during 20 out of the last 40 calendar quarters. For all of these reasons, their DI reciprocity rate would be less than that of the U.S. population; CBO estimates the rate to be about 0.1 percent in 1987, with this rate rising to about 0.7 percent in 1991. Their benefit levels would also be less, reflecting lower than average wages and shorter work histories. The CBO estimates average benefits to be about \$4,300 in 1991.

The Medicaid program provides health care coverage to recipients of AFDC and SSI and to others who may qualify as "medically needy." Under the bill, Medicaid would be provided to aliens on SSI and to children, pregnant women, and emergency cases who could meet Medicaid's eligibility criteria. Costs are estimated to rise from \$1 million in 1987 to \$323 million in 1991. Medicaid beneficiaries are based on numbers of aliens estimated to receive SSI and numbers estimated to receive AFDC who would be children, pregnant women, or in need of emergency services, with some increase for the medically needy. Benefits are current averages per SSI or AFDC enrollee, adjusted to 1987 and later.

Costs in the Medicare program, which provides health care coverage to the aged and disabled covered by Social Security, would rise to \$16 million in 1991. These costs would be for those aliens who would receive DI.

Reimbursements to states for public assistance costs are estimated to cost \$2 million in 1987 and \$527 million in 1991. These reimbursements are based on costs in state and local General Assistance (GA) programs. These programs are fully-funded by states and localities and provide benefits to low-income persons and families who do not qualify for the federally-funded cash welfare programs. GA provides both cash payments and medical coverage. Two groups of aliens would qualify for GA: those who would never be eligible for federal welfare programs (for example, low-income working two-parent families with children, and non-aged, non-disabled couples or single persons without children) and those who would be made ineligible for AFDC by the bill for a period of five years.

Among the first group, CBO estimates that 1.3 percent of the aliens would receive an average annual cash GA benefit of \$1,725 in 1987. This estimate is based on current reciprocity rates and benefit levels in GA programs. Among the second group, CBO's estimate for families who would have qualified for AFDC is based on the assumption that 52 percent of the aliens given resident status would be married men and women, reflecting demographic data on unauthorized aliens, which show about 79 percent to be adults and the majority to be young and male, and marital rates in the United States. Of the married men and women, 4.5 percent of those not of Spanish origin and 17.0 percent of those of Spanish origin are estimated to receive AFDC. These rates of AFDC reciprocity are those which currently exist in the program. The average annual cash benefit for these alien families is estimated to be \$2,150 in 1987. These aliens would also receive medical GA. Their average annual medical benefits are estimated to be \$715 in 1987.

Reimbursements to states for education services are estimated to cost \$1 million in 1987 and \$712 million in 1981. This cost assumes a full appropriation of funds to cover total costs of educating eligible alien children. Of the total legalized alien population, 15 per-

cent—or about 200,000—are estimated to be children of school age. Average per pupil costs were \$3,086 during the 1983–1984 school year, the latest data available. CBO assumes that this 1983–1984 per pupil cost would be used in calculating reimbursements to the states in 1987. This is consistent with current procedures in Chapter I education aid to disadvantaged children. Outlays reflect a spending pattern of 2 percent in the first year, 77 percent in the second year, and 21 percent in the third year.

The table on the following page summarizes the estimated costs associated with Title II.

Agricultural Worker Provisions (Functions 500, 550, 600, and 650).—Title III of the bill provides for the availability of temporary agricultural workers and for the legalization of certain illegal alien workers recently employed in agriculture. CBO estimates the agricultural worker provisions would increase federal outlays by \$56 million in 1987, rising to \$324 million by 1991.

The bill authorizes such sums as may be necessary to enable the Department of Labor (DOL) to make determinations and issue certificates under a new H-2A worker program, targeted at agriculture. The H-2 worker program allows foreign workers to enter the United States temporarily to work in jobs for which employers cannot find domestic workers. In making this estimate, it is assumed that the combination of employer sanctions and a strengthened INS would act as effective deterrents to the hiring of illegals to perform agricultural labor. It is further assumed that the H-2A worker program would expand to fill the otherwise unmet demand for agricultural labor, thereby increasing the administrative costs of DOL.

According to staff from the Department of Agriculture (USDA), if employer sanctions were effectively enforced, growers would need between 250,000 and 500,000 guest workers. Because the CBO assumes that about 250,000 illegal alien workers in agriculture would be legalized under the special agricultural worker provision discussed below, the number of H-2A workers could range up to 250,000 guest workers. The DOL is currently receiving about 800 applications per year for H-2 agricultural workers, and each application requests an average of 25 workers. Administrative costs were about \$3 million in 1985, or \$3,750 per application, for the agricultural part of the H-2 worker program, and they are estimated to increase by about 5 percent per year.

Currently, those illegal immigrants who work in agriculture are located primarily in the West and Southwest, while most H-2 workers are employed in the East. Since western agricultural concerns tend to be far larger than eastern, it is assumed that future applications would be for about 40 workers on average. Using a projected cost per application of about \$4,100 in 1987, CBO estimates that 1987 administrative costs would be \$13 million. This figure is based on an estimated 3,125 applications: 125,000 guest workers—the midpoint of the estimated range noted above—and an estimated 40 workers per application.

ESTIMATED BUDGET IMPACT—LEGALIZATION (FUNCTIONS 550, 570, 600, AND 650)

[By fiscal year, in millions of dollars]

	1987	1988	1989	1990	1991
SSI (Function 600):					
Required budget authority.....	(¹)	23	83	10	116
Estimated outlays.....	(¹)	23	83	10	116
Food stamps (Function 600):					
Estimated authorization level.....	(¹)	1	4	6	6
Estimated outlays.....	(¹)	1	4	6	6
Unemployment compensation (Function 600):					
Required budget authority.....					
Estimated outlays.....	3	47	88	116	115
Disability insurance (Function 650):					
Required budget authority.....					
Estimated outlays.....	(¹)	3	18	38	54
Medicaid (Function 550):					
Required budget authority.....	1	39	156	218	231
Estimated outlays.....	1	39	156	218	231
Medicare (Function 570):					
Required budget authority.....					
Estimated outlays.....	(¹)	(¹)	(¹)	5	16
Reimbursement of State public assistance costs (Function 600):					
Estimated authorization level.....	2	96	370	507	527
Estimated outlays.....	2	96	370	507	527
Payments to States for education costs (Function 600):					
Estimated authorization level.....	70	516	690	717	754
Estimated outlays.....	1	63	423	653	712
Subtotal: Direct spending provisions:					
Required budget authority.....	1	62	239	321	347
Estimated outlays.....	4	112	345	480	532
Subtotal: Amounts subject to appropriation action:					
Estimated authorization level.....	72	613	1,064	1,230	1,288
Estimated outlays.....	4	160	798	1,166	1,245
Total:					
Estimated authorization level.....	73	675	1,303	1,551	1,635
Estimated outlays.....	8	272	1,143	1,646	1,777

¹ Less than \$0.5 million.

In addition, the bill requires the federal government to establish a program to (a) recruit domestic workers to perform services that might otherwise be performed by temporary foreign nonimmigrant laborers, and (b) monitor the terms and conditions under which temporary agricultural workers are employed in the United States. A total of \$10 million per year beginning in 1987 is authorized for these purposes.

The estimated budget impact of the temporary agricultural worker program in H.R. 3810 is summarized in the following table.

ESTIMATED BUDGET IMPACT—TEMPORARY AGRICULTURAL WORKERS (FUNCTION 500)

[By fiscal year, in millions of dollars]

	1987	1988	1989	1990	1991
H-2A Worker Program:					
Estimated authorization level.....	13	13	14	15	15
Estimated outlays.....	13	13	14	15	15
Domestic worker recruitment:					
Authorization level.....	10	10	10	10	10
Estimated outlays.....	10	10	10	10	10

The bill's provision for special agricultural workers would establish legal status for agricultural workers who could demonstrate that they had worked at least 60 days in agricultural employment during the period from May 1, 1985 to May 1, 1986. Since these workers would be provided with legal resident status, federal outlays for entitlement program benefits would rise by an estimated \$5 million in 1987 and \$295 million in 1991.

Workers covered under the special agricultural worker provision are estimated to total about 250,000. This figure was derived by adjusting the number of farm workers upward for turnover during the year and downward for the 60-day work requirement. Further, it is assumed that about 25 percent of farm workers are illegal aliens and that 60 percent would come forward to apply for and be accepted as legal residents. CBO was unable to determine whether the provisions designed to allow additional special agricultural workers beginning in 1990 in the event of a worker shortage would increase the number granted resident status in the future.

Most of the additional entitlement spending would occur in means-tested benefit programs such as AFDC, Medicaid, SSI, and Food Stamps, although the program with the largest increase would be Unemployment Compensation. Unemployment Compensation benefits are estimated to increase from \$5 million in 1987 to \$61 million by 1991. These estimates are based on the assumptions that unemployment rates of agricultural workers are about 75 percent higher than the national average, agricultural wages are lower than overall average wages, and that the average weekly benefit would be about \$97 in 1987. AFDC costs are expected to increase as the number of recipient families is estimated to rise by about 14,000 by 1990. Similarly, the number of SSI recipients is estimated to increase by about 4,600 persons by 1990. Medicaid outlays associated with the increases in AFDC and SSI beneficiaries are estimated to rise by about \$5 million in 1988 and \$53 million by 1991.

Title III also specifies that a commission would be established that would examine the impacts of the special agricultural worker provisions on wages, working conditions, and issues. The CBO estimates that the costs of the commission, including personnel and other non-labor expenses, would be about \$2 million annually over the next five years.

The table on the following page summarizes the estimated costs associated with the special agricultural worker provisions.

Reports to the Congress (Function 750).—Title IV requires the preparation of a number of Presidential reports. These include a comprehensive triennial report on admissions under the Immigration and Nationality Act and the impact of those admissions, reports on unauthorized alien employment and discrimination in employment, biennial reports on the implementation of the temporary agricultural worker program, two reports on the legalization program and its impact, and a report on the visa waiver pilot program. Title VI requires the Attorney General to prepare a report for the Congress on the resources required by the INS to carry out its enforcement and service responsibilities. The cost of these reports is assumed to be included in the amounts authorized for the INS.

In addition, the bill requires the Civil Rights Commission to monitor the implementation and enforcement of the employer sanctions provisions and investigate any allegations of unlawful discrimination due to these provisions. The Commission is to report as to whether implementation and enforcement of these provisions has resulted in a pattern of unlawful discrimination. Implementation of this provision is expected to cost approximately \$1 million each year.

State and Local Assistance for Incarceration of Illegal Aliens and Certain Cuban Nationals (Function 750).—Title V would require the Attorney General to reimburse state and local governments for the costs of imprisoning these aliens and Cuban nationals convicted of felonies and for their pre-trial and post-trial detention. Appropriations are authorized for such sums as are necessary to carry out this provision. CBO estimates that reimbursements would be required for approximately 6,000 prisoners at an average cost of about \$14,000 per prisoner-year in 1987, rising to \$17,000 per year by 1991.

ESTIMATED BUDGET IMPACT—INCARCERATION COSTS (FUNCTION 750)

[By fiscal year, in millions of dollars]

	1987	1988	1989	1990	1991
Estimated authorization level	85	90	95	100	105
Estimated outlays	70	90	95	100	105

Revenues.—CBO assumes that the Attorney General would collect a fee of \$100 for each application submitted by an alien for permanent or temporary residency under the legalization provisions in Title II. CBO estimates that 1.8 million aliens would apply for legal temporary residency—0.6 million in 1987 and 1.2 million in 1988. In 1988 through 1990, the 1.4 million aliens granted temporary residency would apply for permanent residency. The special agricultural workers would also apply for legalization during 1987 and 1988: an estimated 0.1 million in 1987 and 0.2 million in 1988. With a fee of \$100 per application, CBO estimates that the government would receive a total of \$344 million over the four years from legalization application fees.

ESTIMATED BUDGET IMPACT—SPECIAL AGRICULTURAL WORKERS (FUNCTIONS 500, 550, 600, AND 650)

[By fiscal year, in millions of dollars]

	1987	1988	1989	1990	1991
AFDC (Function 600):					
Required budget authority	(1)	6	25	35	36
Estimated outlays	(1)	6	25	35	36
SSI (Function 600):					
Required budget authority	(1)	(1)	16	20	23
Estimated outlays	(1)	(1)	16	20	23
Food Stamps (Function 600):					
Estimated authorization level	(1)	5	23	32	33
Estimated outlays	(1)	5	23	32	33

ESTIMATED BUDGET IMPACT—SPECIAL AGRICULTURAL WORKERS (FUNCTIONS 500, 550, 600, AND 650)—Continued

(By fiscal year, in millions of dollars)

	1987	1988	1989	1990	1991
Unemployment compensation (Function 600):					
Required budget authority.....					
Estimated outlays.....	5	39	59	61	61
Disability Insurance (Function 650):					
Required budget authority.....					
Estimated outlays.....	(¹)	(¹)	(¹)	(¹)	1
Medicaid (Function 550):					
Required budget authority.....	(¹)	5	35	50	53
Estimated outlays.....	(¹)	5	35	50	53
Reimbursement of State public assistance costs (Function 600):					
Estimated authorization level.....	(¹)	12	59	84	88
Estimated outlays.....	(¹)	12	59	84	88
Agricultural Worker Commission (Function 500):					
Estimated authorization level.....	2	2	2	2	2
Estimated outlays.....	2	2	2	2	2
Subtotal: Direct spending provisions:					
Required budget authority.....	(¹)	11	76	105	112
Estimated outlays.....	5	50	135	166	174
Subtotal: Amounts subject to appropriation action:					
Estimated authorization level.....	2	19	84	118	123
Estimated outlays.....	2	19	84	118	123
Total:					
Estimated authorization level/required budget authority.....	(¹)	30	160	222	235
Estimated outlays.....	5	69	219	284	297

¹ Less than \$0.5 million.

In addition, the bill allows the Secretary of Labor to impose a fee on employers importing temporary agricultural workers to recover the costs of processing applications for certification. It has not yet been determined whether the Secretary of Labor would impose such a fee and CBO is unable at this time to estimate how much money would be collected as a result of this fee. Also, the bill permanently exempts employers from paying Federal Unemployment Tax Act taxes on wages paid to H-2 agricultural workers. This provision has a negligible revenue effect.

Part B to Title I increases penalties for immigration-related violations and Part A outlines employer penalties for illegal employment of unauthorized aliens. No estimate can be made of the fines that would be collected by the federal government as a result of these sections.

In addition to the above effects on federal revenues, there are potential effects on individual income tax revenues and social insurance contributions. Revenues would increase if some of the aliens who are not having taxes withheld from their wages at present were to have taxes withheld as a result of this legislation. Revenues would decrease if aliens who currently have taxes withheld and are entitled to refunds that they do not claim would claim refunds as a result of this bill. Given the uncertainties concerning characteristics of illegal aliens, and rough estimates showing the two effects above to be approximately offsetting, CBO shows no effect of the bill on these revenue sources.

ESTIMATED REVENUE EFFECT

[By fiscal year, in millions of dollars]

	1987	1988	1989	1990	1991
Revenues from application fees.....	70	166	54	54	.....

6. Estimated cost to state and local governments: By legalizing certain unauthorized aliens currently residing in the United States, this bill could have sizable effects on state and local government budgets. Unauthorized aliens are not eligible for welfare programs that are partially- or full-funded by states and localities. When legalized, these aliens would be eligible for such programs—immediately in the case of state programs and after five years in the case of programs financed by federal and state governments jointly. The special agricultural workers would be eligible for federal and state programs immediately. During the estimation period, however, states and localities would have no added costs under CBO's assumptions. They would, in fact, experience budgetary savings to the extent funds were appropriated to cover their public assistance, education, and imprisonment costs, as authorized in the bill. After 1991, however, when the public assistance and education reimbursements were no longer available, states and localities would experience increased costs.

As shown in the table, public assistance costs would be zero to the extent the authorized reimbursements covered them in full, as CBO has assumed. The full amounts of any reimbursements for education services are estimated to result in state and local savings. States were required to educate illegal alien children by the Supreme Court in *Plyler vs. Doe* (June 15, 1982). Finally, any reimbursements for costs of incarcerating illegal aliens currently borne by states and localities would also result in budgetary savings.

[By fiscal year, in millions of dollars]

	1987	1988	1989	1990	1991
Public assistance.....					
Education assistance.....	-1	-63	-423	-653	-712
Assistance for imprisonment costs.....	-70	-90	-95	-100	-105
Total estimated state and local outlays.....	-71	-153	-518	-753	-817

A number of factors make these estimates uncertain. For purposes of this estimate, it is assumed that funds for reimbursements to states would be appropriated in full. If less than this amount were appropriated, states and localities would have lower savings or even experience budgetary costs. On the other hand, with a full appropriation, savings to states and localities would be higher than CBO has estimated. Certain current expenditures by states and localities would be covered under the grant: free health care provided to unauthorized aliens in public hospitals, assistance to Cuban and Haitian entrants, and any public assistance being received ille-

tail the entry and stay of unauthorized aliens before legalization could proceed.

9. Estimate prepared by: Janice Peskin, Marjorie Miller, Linda Radey, Paul Cullinan, Lynne Davidson, Julia Isaacs, and Anne Manley.

10. Estimate approved by: C.G. Nuckols, for James L. Blum, Assistant Director for Budget Analysis.

COMMITTEE RECOMMENDATION

After careful consideration of this legislation, the Committee is of the opinion that this bill should be enacted and accordingly recommends that H.R. 3810, as amended, do pass.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

IMMIGRATION AND NATIONALITY ACT

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* * * * *

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TITLE I—GENERAL

DEFINITIONS

SECTION 101. (a) As used in this Act—

(1) * * *

* * * * *

- (15) The term “immigrant” means every alien except an alien who is within one of the following classes of nonimmigrant aliens—

(A) * * *

* * * * *

(H) an alien having a residence in a foreign country which he has no intention of abandoning (i) who is of distinguished merit and ability and who is coming temporarily to the United States to perform services of an exceptional nature requiring such merit and ability, and who, in the case of a graduate of a medical school coming to the United States to perform services as a member of the medical profession, is coming pursuant to an invitation from a public or nonprofit private educational or research institution or agency in the United States to teach or conduct research, or both, at or for such institution or agency; or (ii) who is coming temporarily to the United States [to perform temporary services or labor,] *(a) to perform agricultural labor or services, as defined by the Secretary of Labor in regulations and including agricultural labor defined in section 3121(g) of the Internal Revenue Code of 1954 and agriculture as defined in section 3(f) of the Fair Labor Standards Act of 1938 (29 U.S.C. 203(f)), of a temporary or seasonal nature, or (b) to perform other temporary service or labor if unemployed persons capable of performing such service or labor cannot be found in this country, but this clause shall not apply to graduates of medical schools coming to the United States to perform services as members of the medical profession; or (iii) who is coming temporarily to the United States as a trainee, other*

the application period, and until a final determination on the application has been made in accordance with this section, the alien—

(A) may not be deported, and

(B) shall be granted authorization to engage in employment in the United States and be provided an "employment authorized" endorsement or other appropriate work permit.

(f) ADMINISTRATIVE AND JUDICIAL REVIEW.—

(1) ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review of a determination respecting an application for adjustment of status under this section except in accordance with this subsection.

(2) ADMINISTRATIVE REVIEW.—

(A) SINGLE LEVEL OF ADMINISTRATIVE APPELLATE REVIEW.—The Attorney General shall establish an appellate authority to provide for a single level of administrative appellate review of such a determination.

(B) STANDARD FOR REVIEW.—Such administrative appellate review shall be based solely upon the administrative record established at the time of the determination on the application and upon such additional or newly discovered evidence as may not have been available at the time of the determination.

(3) JUDICIAL REVIEW.—

(A) LIMITATION TO REVIEW OF DEPORTATION.—There shall be judicial review of such a denial only in the judicial review of an order of deportation under section 106.

(B) STANDARD FOR JUDICIAL REVIEW.—Such judicial review shall be based solely upon the administrative record established at the time of the review by the appellate authority and the findings of fact and determinations contained in such record shall be conclusive unless the applicant can establish abuse of discretion or that the findings are directly contrary to clear and convincing facts contained in the record considered as a whole.

(g) REGULATIONS IMPLEMENTING SECTION.—*The Attorney General, after consultation with the Committees on the Judiciary of the House of Representatives and of the Senate and with qualified designated entities, shall prescribe—*

(1) regulations establishing a definition of the term "resided continuously", as used in this section, and the evidence needed to establish that an alien has resided continuously in the United States for purposes of this section, and

(2) such other regulations as may be necessary to carry out this section.

Such regulations may be prescribed to take effect on an interim final basis if the Attorney General determines that this is necessary in order to implement this section in a timely manner.

(h) TEMPORARY DISQUALIFICATION OF NEWLY LEGALIZED ALIENS FROM RECEIVING CERTAIN PUBLIC WELFARE ASSISTANCE.—

(1) IN GENERAL.—During the five-year period beginning on the date an alien was granted lawful temporary resident status under subsection (a), and notwithstanding any other provision of law—

(A) except as provided in paragraph (2), the alien is not eligible for—

(i) any program of financial assistance furnished under Federal law (whether through grant, loan, guarantee, or otherwise) on the basis of financial need, as such programs are identified by the Attorney General in consultation with other appropriate heads of the various departments and agencies of Government,

(ii) medical assistance under a State plan approved under title XIX of the Social Security Act, and

(iii) assistance under the Food Stamp Act of 1977; and

(B) a State or political subdivision therein may, to the extent consistent with subparagraph (A), provide that the alien is not eligible for the programs of financial assistance or for medical assistance described in subparagraph (A)(ii) furnished under the law of that State or political subdivision.

(2) **EXCEPTIONS.**—Paragraph (1) shall not apply—

(A) to a Cuban and Haitian entrant (as defined in paragraph (1) or (2)(A) of section 501(e) of Public Law 96-422, as in effect on April 1, 1983),

(B) in the case of assistance furnished to an alien who is an aged, blind, or disabled individual (as defined in section 1614(a)(1) of the Social Security Act), or

(C) in the case of medical assistance (i) for care and services provided to an alien who is under 18 years of age, (ii) for emergency services (as defined for purposes of section 1916(a)(2)(D) of the Social Security Act) or (iii) for services described in section 1916(a)(2)(B) of such Act (relating to services for pregnant women).

(3) **TREATMENT OF CERTAIN PROGRAMS.**—Assistance furnished under any of the following provisions of law shall not be construed to be financial assistance described in paragraph (1)(A)(i):

(A) The National School Lunch Act.

(B) The Child Nutrition Act of 1966.

(C) The Vocational Education Act of 1963.

(D) Chapter 1 of the Education Consolidation and Improvement Act of 1981.

(E) The Headstart-Follow Through Act.

(F) The Job Training Partnership Act.

(G) Subparts 4 and 5 of part A of title IV of the Higher Education Act of 1965.

(H) The Public Health Service Act.

(I) Title V of the Social Security Act.

(4) **ADJUSTMENT NOT AFFECTING FASCCELL-STONE BENEFITS.**—For the purpose of section 501 of the Refugee Education Assistance Act of 1980 (Public Law 96-122), assistance shall be continued under such section with respect to an alien without regard to the alien's adjustment of status under this section.

(5) **MODIFICATION OF MEDICAID REQUIREMENTS.**—The eligibility, comparability, and any other State plan requirements of title XIX of the Social Security Act are superceded to the extent

required to restrict the medical assistance in the manner described in this subsection. The Secretary of Health and Human Services, in coordination with the Attorney General, shall promulgate regulations in order to carry out this subsection.

(i) **DISSEMINATION OF INFORMATION ON LEGALIZATION PROGRAM.**—*Beginning not later than the date designated by the Attorney General under subsection (a)(1)(A), the Attorney General, in cooperation with designated entities, shall broadly disseminate in English and other appropriate languages information respecting the benefits which aliens may receive under this section and the requirements to obtain such benefits. Such information shall include—*

(1) information respecting the requirements that aliens with lawful temporary resident status would have to meet to have their status adjusted to permanent resident status under subsection (b)(1) and the facilities available to provide education and employment training and opportunities in order to meet such requirements;

(2) information on the conditions under which temporary lawful resident status can be rescinded under subsection (b)(2); and

(3) information on conditions for employment and foreign travel of aliens with lawful temporary resident status under subsection (b)(3).

* * * * *

CHANGE OF NONIMMIGRANT CLASSIFICATION

SEC. 248. The Attorney General may, under such conditions as he may prescribe, authorize a change from any nonimmigrant classification to any other nonimmigrant classification in the case of any alien lawfully admitted to the United States as a nonimmigrant who is continuing to maintain that status, except in the case of—

(1) an alien classified as a nonimmigrant under subparagraph (C), (D), or (K) of section 101(a)(15),

(2) an alien classified as a nonimmigrant under subparagraph (J) of section 101(a)(15) who came to the United States or acquired such classification in order to receive graduate medical education or training, **[and]**

(3) an alien (other than an alien described in paragraph (2)) classified as a nonimmigrant under subparagraph (J) of section 101(a)(15) who is subject to the two-year foreign residence requirement of section 212(e) and has not received a waiver thereof, unless such alien applies to have the alien's classification changed from classification under subparagraph (J) of section 101(a)(15) to a classification under subparagraph (A) or (G) of such section **[.]**, *and*

(4) *an alien admitted as a nonimmigrant visitor without a visa under section 212(1) or section 217.*

(A) an alien knowing the alien is an unauthorized alien (as defined in subsection (g)) with respect to such employment, or

(B) an individual without complying with the requirements of subsection (b).

(2) **CONTINUING EMPLOYMENT.**—It is unlawful for a person or other entity, after hiring an alien for employment subsequent to the date of the enactment of this section and in accordance with paragraph (1), to continue to employ the alien in the United States knowing the alien is (or has become) an unauthorized alien with respect to such employment.

(3) **DEFENSE.**—A person or entity that establishes that it has complied in good faith with the requirements of subsection (b) with respect to the hiring, recruiting, or referral for employment of an alien in the United States has established an affirmative defense that the person or entity has not violated paragraph (1)(A) with respect to such hiring, recruiting, or referral.

(4) **USE OF LABOR THROUGH CONTRACT.**—For purposes of this section, a person or other entity who uses a contract, subcontract, or exchange, entered into, renegotiated, or extended after the date of the enactment of this section, to obtain the labor of an alien in the United States knowing that the alien is an unauthorized alien (as defined in subsection (g)) with respect to performing such labor, shall be considered to have hired the alien for employment in the United States in violation of paragraph (1)(A).

(5) **USE OF STATE EMPLOYMENT AGENCY DOCUMENTATION.**—For purposes of paragraphs (1)(B) and (3), a person or entity shall be deemed to have complied with the requirements of subsection (b) with respect to the hiring of an individual who was referred for such employment by a State employment agency (as defined by the Attorney General), if the person or entity has and retains (for the period and in the manner described in subsection (b)(3)) appropriate documentation of such referral by that agency, which documentation certifies that the agency has complied with the procedures specified in subsection (b) with respect to the individual's referral.

(b) **EMPLOYMENT VERIFICATION SYSTEM.**—The requirements referred to in paragraphs (1)(B) and (3) of subsection (a) are, in the case of a person or other entity hiring, recruiting, or referring an individual for employment in the United States, the requirements specified in the following three paragraphs (and, to the extent applicable, paragraph (7)(C)):

(1) **ATTESTATION AFTER EXAMINATION OF DOCUMENTATION AND VALIDATION OF SOCIAL SECURITY ACCOUNT NUMBER.**—

(A) **IN GENERAL.**—The person or entity must attest, under penalty of perjury and on a form established or designated by the Attorney General by regulation, that he has verified that the individual is eligible to be employed (or recruited or referred for employment) in the United States—

(i) by examining—

(I) the individual's United States passport, or the individual's unexpired foreign passport, if the foreign passport has an appropriate, unexpired en-

dorsement of the Attorney General authorizing the individual's employment in the United States, or

(II) a document described in subparagraph (B) and a document described in subparagraph (C); and

(ii) by validating (to the extent and in the manner required under paragraph (7)(C)) the social security account number presented by the individual.

A person or entity has complied with the requirement of clause (i) of this subparagraph with respect to examination of a document if the document reasonably appears on its face to be genuine. If an individual provides a document or combination of documents that reasonably appears on its face to be genuine and that is sufficient to meet the requirements of clause (i), nothing in this paragraph shall be construed as requiring the person or entity to solicit the production of any other document or as requiring the individual to produce such a document.

(B) **DOCUMENTS EVIDENCING EMPLOYMENT AUTHORIZATION.**—A document described in this subparagraph is the individual's—

(i) social security account number card issued by the Social Security Administration,

(ii) certificate of birth in the United States or United States consular report of birth, or

(iii) in the case of an individual without a social security card or a certificate of birth in the United States or a United States consular report of birth, any other identification acceptable to the Attorney General.

(C) **DOCUMENTS ESTABLISHING IDENTITY OF INDIVIDUAL.**—A document described in this subparagraph is the individual's—

(i) alien documentation, identification, and telecommunication card, or similar fraud-resistant card issued by the Attorney General to aliens, or other identification issued by the Attorney General to aliens who establish eligibility for employment,

(ii) driver's license or similar document issued for the purpose of identification by a State, if it contains a photograph of the individual or such other personal identifying information relating to the individual as the Attorney General finds, by regulation, sufficient for purposes of this section, or

(iii) in the case of individuals under 16 years of age or in a State which does not provide for issuance of an identification document (other than a driver's license) referred to in clause (ii), documentation of personal identity of such other type as the Attorney General finds, by regulation, provides a reliable means of identification.

(2) **INDIVIDUAL ATTESTATION OF EMPLOYMENT AUTHORIZATION.**—The individual must attest, under penalty of perjury and on the form designated or established by the Attorney General for purposes of paragraph (1), that the individual is a citi-

zen or national of the United States, an alien lawfully admitted for permanent residence, or an alien who is authorized under this Act or by the Attorney General to be hired, recruited, or referred for such employment.

(3) **RETENTION OF VERIFICATION FORM.**—After completion of such form in accordance with paragraphs (1) and (2), the person or entity must retain the form and make it available for inspection by officers of the Service or of the Department of Labor during such period as the Attorney General shall specify in regulations.

(4) **COPYING OF DOCUMENTATION PERMITTED.**—Notwithstanding any other provision of law, the person or entity may copy a document presented by an individual pursuant to this subsection and may retain the copy, but only (except as otherwise permitted under law) for the purpose of complying with the requirements of this subsection.

(5) **TIME FOR COMPLIANCE.**—A person or entity has complied with the requirements of this subsection, with respect to the hiring of an individual, if the requirements of this subsection are first met not later than noon of the day following the day on which the individual is first employed by that person or entity.

(6) **LIMITATION ON USE OF ATTESTATION FORM.**—A form designated or established by the Attorney General under this subsection and any information contained in or appended to such form, may not be used for purposes other than for enforcement of this section or section 1546 of title 18, United States Code.

(7) **SOCIAL SECURITY ACCOUNT NUMBER VALIDATION SYSTEM.**—

(A) **ESTABLISHMENT OF SYSTEM.**—The Attorney General, in cooperation with the Secretaries of Labor and Health and Human Services, shall establish a method to validate the social security account numbers of individuals applying to be hired, or recruited or referred for a fee, for employment in the United States.

(B) **PUBLICATION.**—The Attorney General shall provide for publication in the Federal Register of notice of the establishment of the validation method and the procedures for its use not earlier than 6 months, and not later than 18 months, after the date of the enactment of this section.

(C) **IMPLEMENTATION.**—Beginning on an effective date (not earlier than 90 days, and not later than 180 days, after the date final regulations are published under subparagraph (B)) set forth by the Attorney General, in order to comply with the requirement of paragraph (1)(A) of this subsection in the case of a person or other entity hiring, or recruiting or referring for a fee, an individual for employment in the United States, the person or other entity must, pursuant to the verification method—

(i) submit the social security account number of the individual, and

(ii) be provided and record on the form designated or established for purposes of that paragraph a validation code indicating that the number submitted is valid.

(c) **NO AUTHORIZATION OF NATIONAL IDENTIFICATION CARDS.**—Nothing in this section shall be construed to authorize, directly or indirectly, the issuance or use of national identification cards or the establishment of a national identification card.

(d) **PENALTIES.**—

(1) **CIVIL MONEY PENALTY FOR UNLAWFUL EMPLOYMENT, RECRUITING, OR REFERRAL.**—

(A) **IN GENERAL.**—In the case of a person or entity which is determined (after notice and opportunity for an administrative hearing under paragraph (4)(A)) to have violated paragraph (1)(A) or (2) of subsection (a) and which—

(i) has not previously been determined (after opportunity for a hearing under paragraph (4)(A)) to have violated either such paragraph, the person or entity shall be subject to a civil penalty of not less than \$1,000, and not more than \$2,000, for each unauthorized alien with respect to whom the violation occurred, or

(ii) has previously been determined (after opportunity for a hearing under paragraph (4)(A)) to have violated either such paragraph, the person or entity shall be subject to a civil penalty of not less than \$2,000, and not more than \$5,000, for each unauthorized alien with respect to whom the violation occurred.

In determining the level of civil penalty that is applicable under this subparagraph for violations of paragraph (1)(A) or (2) of subsection (a), determinations of more than one violation in the course of a single proceeding or adjudication shall be counted as a single determination.

(B) **CRIMINAL PENALTY FOR PATTERN OR PRACTICE VIOLATIONS.**—In the case of a person or entity which has engaged in a pattern or practice of employment, recruitment, or referral in violation of paragraph (1)(A) or (2) of subsection (a), the person or entity shall be fined not more than \$1,000, imprisoned not more than six months, or both, for each violation.

(2) **ENJOINING OF PATTERN OR PRACTICE VIOLATIONS.**—Whenever the Attorney General has reasonable cause to believe that a person or entity is engaged in a pattern or practice of employment, recruitment, or referral in violation of paragraph (1)(A) or (2) of subsection (a), the Attorney General may bring a civil action in the appropriate district court of the United States requesting such relief, including a permanent or temporary injunction, restraining order, or other order against the person or entity, as the Attorney General deems necessary.

(3) **CIVIL MONEY PENALTY FOR PAPERWORK VIOLATIONS.**—A person or entity which is determined (after notice and opportunity for an administrative hearing under paragraph (4)(A)) to have violated subsection (a)(1)(B) shall be subject to a civil penalty of not less than \$250 and not more than \$1,000 for each individual with respect to whom such violation occurred. In determining the amount of the penalty, due consideration shall be given to the size of the business of the employer being charged, the good faith of the employer, the seriousness of the violation, and the history of previous violations.

contractor shall, upon conviction, be fined not more than \$10,000 or sentenced to prison for a term not to exceed three years, or both.

* * * * *

SOCIAL SECURITY ACT

* * * * *

PAYMENT TO STATES

SEC. 3. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing October 1, 1960—

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as old-age assistance under the State plan, not counting so much of any expenditure with respect to any month as exceeds \$37.50 multiplied by the total number of recipients of old-age assistance for such month; plus

(4) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and efficient administration of the State plan—

(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

(B) 100 percent of so much of such expenditures as are for the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus

[(B)] (C) one-half of the remainder of such expenditures.

* * * * *

TITLE III—GRANTS TO STATES FOR UNEMPLOYMENT COMPENSATION ADMINISTRATION

* * * * *

PAYMENTS TO STATES

SEC. 302. (a) The Secretary of Labor shall from time to time certify to the Secretary of the Treasury for payment to each State which has an unemployment compensation law approved by the Secretary of Labor under the Federal Unemployment Tax Act, such amounts as the Secretary of Labor determines to be necessary for the proper and efficient administration of such law during the

fiscal year for which such payment is to be made, *including 100 percent of so much of the reasonable expenditures of the State as are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1137(d).* The Secretary of Labor's determination shall be based on (1) the population of the State; (2) an estimate of the number of persons covered by the State law and of the cost of proper and efficient administration of such law; and (3) such other factors as the Secretary of Labor finds relevant. The Secretary of Labor shall not certify for payment under this section in any fiscal year a total amount in excess of the amount appropriated therefor for such fiscal year.

* * * * *

TITLE IV—GRANTS TO STATES FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN AND FOR CHILD-WELFARE SERVICES

* * * * *

PART A—AID TO FAMILIES WITH DEPENDENT CHILDREN

* * * * *

PAYMENT TO STATES

SEC. 403. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid and services to needy families with children, for each quarter, beginning with the quarter commencing October 1, 1958—

(1) * * *

* * * * *

(3) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan—

(A) 100 percent of so much of such expenditures as are for the costs of the implementation and operation of the immigration status verification system described in section 1137(d),

* * * * *

TITLE X—GRANTS TO STATES FOR AID TO THE BLIND

* * * * *

PAYMENT TO STATES

SEC. 1003. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid to the blind, for each quarter, beginning with the quarter commencing October 1, 1958—

* * * * *

(3) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during

such quarter as found necessary by the Secretary of Health and Human Services for the proper and efficient administration of the State plan—

(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

(B) 100 percent of so much of such expenditures as are for the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus

[(B)] (C) one-half of the remainder of such expenditures.

* * * * *

TITLE XI—GENERAL PROVISIONS AND PEER REVIEW

* * * * *

PART A—GENERAL PROVISIONS

* * * * *

INCOME AND ELIGIBILITY VERIFICATION SYSTEM

SEC. 1137. (a) In order to meet the requirements of this section, a State must have in effect an income and eligibility verification system *which meets the requirements of subsection (d) and under which—*

(1) the State shall require, as a condition of eligibility for benefits under any program listed in subsection (b), that each applicant for or recipient of benefits under that program furnish to the State his social security account number (or numbers, if he has more than one such number), and the State shall utilize such account numbers in the administration of that program so as to enable the association of the records pertaining to the applicant or recipient with his account number;

* * * * *

(b) The programs which must participate in the income *and eligibility* verification system are—

(1) the aid to families with dependent children program under part A of title IV of this Act;

(2) the medicaid program under title XIX of this Act;

(3) the unemployment compensation program under section 3304 of the Internal Revenue Code of 1954;

(4) the food stamp program under the Food Stamp Act of 1977; and

(5) any State program under a plan approved under title I, X, XIV, or XVI of this Act.

* * * * *

(d) *The requirements of this subsection, with respect to an income and eligibility verification system of a State, are as follows:*

(1)(A) *The State shall require, as a condition of an individual's eligibility for benefits under any program listed in subsection (b), a declaration in writing by the individual (or, in the case of an individual who is a child, by another on the individual's behalf), under penalty of perjury, stating whether or not the individual is a citizen or national of the United States, and, if that individual is not a citizen or national of the United States, that the individual is in a satisfactory immigration status.*

(B) *In this subsection—*

(i) *in the case of the program described in subsection (b)(1), any reference to an individual's eligibility for benefits under the program shall be considered a reference to the individual's being considered a dependent child or to the individual's being treated as a caretaker relative or other person whose needs are to be taken into account in making the determination under section 402(a)(7),*

(ii) *in the case of the program described in subsection (b)(4)—*

(I) *any reference to the State shall be considered a reference to the State agency, and*

(II) *any reference to an individual's eligibility for benefits under the program shall be considered a reference to the individual's eligibility to participate in the program as a member of a household, and*

(III) *the term "satisfactory immigration status" means an immigration status which does not make the individual ineligible for benefits under the applicable program.*

(2) *If such an individual is not a citizen or national of the United States, there must be presented either—*

(A) *alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual's alien admission number or alien file number (or numbers if the individual has more than one number), or*

(B) *such other documents as the State determines constitutes reasonable evidence indicating a satisfactory immigration status.*

(3) *If the documentation described in paragraph (2)(A) is presented, the State shall utilize the individual's alien file or alien admission number to verify with the Immigration and Naturalization Service the individual's immigration status through an automated or other system (designated by the Service for use with States) that—*

(A) *utilizes the individual's name, file number, admission number, or other means permitting efficient verification, and*

(B) *protects the individual's privacy to the maximum degree possible.*

(4) *In the case of such an individual who is not a citizen or national of the United States, if, at the time of application for*

benefits, the statement described in paragraph (1) is submitted but the documentation required under paragraph (2) is not presented or if the documentation required under paragraph (2)(A) is presented but such documentation is not verified under paragraph (3)—

(A) the State—

(i) shall provide a reasonable opportunity to submit to the State evidence indicating a satisfactory immigration status, and

(ii) may not delay, deny, reduce, or terminate the individual's eligibility for benefits under the program on the basis of the individual's immigration status until such a reasonable opportunity has been provided; and

(B) if there are submitted documents which the State determines constitutes reasonable evidence indicating such status—

(i) the State shall transmit to the Immigration and Naturalization Service photostatic or other similar copies of such documents for official verification,

(ii) pending such verification, the State may not delay, deny, reduce, or terminate the individual's eligibility for benefits under the program on the basis of the individual's immigration status, and

(iii) the State shall not be liable for the consequences of any action, delay, or failure of the Service to conduct such verification.

(5) If the State determines, after complying with the requirements of paragraph (4), that such an individual is not in a satisfactory immigration status under the applicable program—

(A) the State shall deny or terminate the individual's eligibility for benefits under the program, and

(B) the applicable fair hearing process shall be made available with respect to the individual.

(e) Each Federal agency responsible for administration of a program described in subsection (b) shall not take any compliance, disallowance, penalty, or other regulatory action against a State with respect to any error in the State's determination to make an individual eligible for benefits based on citizenship or immigration status—

(1) if the State has provided such eligibility based on a verification of satisfactory immigration status by the Immigration and Naturalization Service,

(2) because the State, under subsection (d)(4)(A)(ii), was required to provide a reasonable opportunity to submit documentation,

(3) because the State, under subsection (d)(4)(B)(ii), was required to wait for the response of the Immigration and Naturalization Service to the State's request for official verification of the immigration status of the individual, or

(4) because of a fair hearing process described in subsection (d)(5)(B).

TITLE XIV—GRANTS TO STATES FOR AID TO THE PERMANENTLY AND TOTALLY DISABLED

* * * * *

PAYMENTS TO STATES

SEC. 1403. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid to the permanently and totally disabled, for each quarter, beginning with the quarter commencing October 1, 1958—

* * * * *

(3) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and official administration of the State plan—

(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

* * * * *

(B) 100 percent of so much of such expenditures as are for the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus

[B] (C) one-half of the remainder of such expenditures.

* * * * *

TITLE XVI—GRANTS TO STATES FOR AID TO THE AGED, BLIND, OR DISABLED

* * * * *

PAYMENTS TO STATES

SEC. 1603. (a) From the sums appropriated therefor, the Secretary shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing October 1, 1962—

* * * * *

(4) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and efficient administration of the State plan—

(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such

institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

* * * * *

(B) 100 percent of so much of such expenditures as are for the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus

[B] (C) one-half of the remainder of such expenditures.

* * * * *

TITLE XVI—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

* * * * *

PART B—PROCEDURAL AND GENERAL PROVISIONS

PAYMENTS AND PROCEDURES

Payment of Benefits

SEC. 1631. (a) * * *

* * * * *

Applications and Furnishing of Information

(e)(1)(A) The Secretary shall, subject to subparagraph (B), prescribe such requirements with respect to the filing of applications, the suspension or termination of assistance, the furnishing of other data and material, and the reporting of events and changes in circumstances, as may be necessary for the effective and efficient administration of this title.

(B) The requirements prescribed by the Secretary pursuant to subparagraph (A) shall require that eligibility for benefits under this title will not be determined solely on the basis of declarations by the applicant concerning eligibility factors or other relevant facts, and that relevant information will be verified from independent or collateral sources and additional information obtained as necessary in order to assure that such benefits are only provided to eligible individuals (or eligible spouses) and that the amounts of such benefits are correct. For this purpose and for purposes of federally administered supplementary payments of the type described in section 1616(a) of this Act (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93-66), the Secretary shall, as may be necessary, request and utilize information available pursuant to section 6103(1)(7) of the Internal Revenue Code of 1954, and any information which may be available from State systems under section 1137 of this Act, and shall comply with the requirements applicable to States (with respect to infor-

mation available pursuant to section 6103(1)(7)(B) of such Code) under subsections (a)(6) [and (c)], (c), and (d) of such section 1137.

* * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * *

PAYMENT TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) * * *

* * * * *

(4) an amount equal to 100 percent of the sums expended during the quarter which are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus

* * * * *

SECTION 214 OF THE HOUSING AND COMMUNITY DEVELOPMENT ACT OF 1980

RESTRICTION ON USE OF ASSISTED HOUSING

SEC. 214.¹ (a) * * *

* * * * *

(d) The following conditions apply with respect to financial assistance being provided for the benefit of an individual:

(1)(A) There must be a declaration in writing by the individual (or, in the case of an individual who is a child, by another on the individual's behalf), under penalty of perjury, stating whether or not the individual is a citizen or national of the United States, and, if that individual is not a citizen or national of the United States, that the individual is in a satisfactory immigration status.

(B) In this subsection, the term "satisfactory immigration status" means an immigration status which does not make the individual ineligible for financial assistance.

(2) If such an individual is not a citizen or national of the United States, there must be presented either—

(A) alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual's alien admission number or alien file number (or numbers if the individual has more than one number), or

IMMIGRATION CONTROL AND LEGALIZATION AMENDMENTS ACT OF 1986

AUGUST 5, 1986.—Ordered to be printed

Mr. HAWKINS, from the Committee on Education and Labor,
submitted the following

REPORT

together with

MINORITY AND ADDITIONAL VIEWS

[To accompany H.R. 3810]

[Including cost estimate of the Congressional Budget Office]

The Committee on Education and Labor, to whom was referred the bill (H.R. 3810) to amend the Immigration and Nationality Act to revise and reform the immigration laws, and for other purposes, having considered the same, report those provisions of the bill within the jurisdiction of the Committee with amendments and recommend that the provisions as amended be agreed to.

The amendments (stated in terms of page and line numbers of the bill as reported by the Committee on the Judiciary) are as follows:

AMENDMENT NO. 1

Page, 5, strike out lines 11 through 23.

AMENDMENT NO. 2

Page 6, line 5, and page 7, line 6, strike out “(7)(C)” and insert in lieu thereof “(6)(C)”.

Page 10, strike out lines 8 through 14.

Page 10, lines 15 and 21, strike out “(6) and “(7)”, respectively, and insert in lieu thereof “(5)” and “(6)”, respectively.

“(4) there is a subsequent determination that, because of an unsatisfactory immigration status, the individual is not eligible for the loan, the official of the institution making the determination shall notify and instruct the entity making the loan to cease further payments under the loan, but such guaranty shall not be voided or otherwise nullified with respect to such payments made before the date the entity receives the notice.”.

Page 60, after line 11, insert the following:

(7) UNDER TITLE IV EDUCATIONAL ASSISTANCE.—Section 489(a) of the Higher Education Act of 1965 (20 U.S.C. 1096) is amended by adding at the end the following: “In addition, the Secretary shall provide for payment to each institution of higher education an amount equal to 100 percent of the costs incurred by the institution in implementing and operating the immigration status verification system under section 484(c).”.

Page 61, after line 14, insert the following new subsection:

(d) GAO REPORTS.—

(1) REPORT ON CURRENT PILOT PROJECTS.—The Comptroller General shall—

(A) examine current pilot projects relating to the System for Alien Verification of Eligibility (SAVE) operated by, or through cooperative agreements with, the Immigration and Naturalization Service, and

(B) report, not later than October 1, 1987, to Congress and to the Commissioner of the Immigration and Naturalization Service concerning the effectiveness of such projects and any problems with the implementation of such projects, particularly as they may apply to implementation of the system referred to in subsection (c)(1).

(2) REPORT ON IMPLEMENTATION OF VERIFICATION SYSTEM.—The Comptroller General shall—

(A) monitor and analyze the implementation of such system,

(B) report to Congress and to the appropriate Secretaries described in subsection (c)(4)(D)(ii), by not later than April 1, 1989, on such implementation, and

(C) include in such report such recommendations for changes in the system as may be appropriate.

Page 61, line 7, strike “The amendments” and insert “Except as provided in paragraph (4), the amendments”.

Page 61, after line 10, insert the following new paragraph (and redesignate the succeeding paragraph accordingly):

(4) **USE OF VERIFICATION SYSTEM NOT REQUIRED FOR A PROGRAM IN CERTAIN CASES.—**

(A) **REPORT TO RESPECTIVE CONGRESSIONAL COMMITTEES.—**

With respect to each covered program (as defined in subparagraph (D)(i)), each appropriate Secretary shall examine and report to the appropriate Committees of the House of Representatives and of the Senate, by not later than April 1, 1988, concerning whether (and the extent to which)—

(i) the application of the amendments made by subsection (a) to the program is cost-effective and otherwise appropriate, and

(ii) there should be a waiver of the application of such amendments under subparagraph (B).

The amendments made by subsection (a) shall not apply with respect to a covered program until after the date of receipt of such report with respect to the program.

(B) **WAIVER IN CERTAIN CASES.—**If, with respect to a covered program, the appropriate Secretary determines, on the Secretary's own initiative or upon an application by an administering entity and based on such information as the Secretary deems persuasive (which may include the results of the report required under subsection (d)(1) and information contained in such an application), that—

(i) the appropriate Secretary or the administering entity has in effect an alternative system of immigration status verification which—

(I) is as effective, accurate, and timely as the system otherwise required under the amendments made by subsection (a) with respect to the program, and

(II) provides for at least the hearing and appeals rights for beneficiaries that would be provided under the amendments made by subsection (a), or

(ii) the costs of administration of the system otherwise required under such amendments exceed the estimated savings,

such Secretary may waive the application of such amendments to the covered program to the extent (by State or other geographic area or otherwise) that such determinations apply.

(C) **BASIS FOR DETERMINATION.—**A determination under subparagraph (B)(ii) shall be based upon the appropriate Secretary's estimate of—

(i) the number of aliens claiming benefits under the covered program in relation to the total number of claimants seeking benefits under the program,

(ii) any savings in benefit expenditures reasonably expected to result from implementation of the verification program, and

(iii) the labor and nonlabor costs of administration of the verification system,

the degree to which the Immigration and Naturalization Service is capable of providing timely and accurate infor-

mation to the administering entity in order to permit a reliable determination of immigration status, and such other factors as such Secretary deems relevant.

(D) DEFINITIONS.—In this paragraph:

(i) The term “covered program” means each of the following programs:

(I) The aid to families with dependent children program under part A of title IV of the Social Security Act.

(II) The medicaid program under title XIX of the Social Security Act.

(III) The supplemental security income program under title XVI of the Social Security Act.

(IV) Any State program under a plan approved under title I, X, XIV, or XVI of the Social Security Act.

(V) The unemployment compensation program under section 3304 of the Internal Revenue Code of 1954.

(VI) The food stamp program under the Food Stamp Act of 1977.

(VII) The programs of financial assistance for housing subject to section 214 of the Housing and Community Development Act of 1980.

(VIII) The program of grants, loans, and work assistance under title IV of the Higher Education Act of 1965.

(ii) The term “appropriate Secretary” means, with respect to the covered program described in—

(I) subclauses (I) through (IV) of clause (i), the Secretary of Health and Human Services;

(II) clause (i)(V), the Secretary of Labor;

(III) clause (i)(VI), the Secretary of Agriculture;

(IV) clause (i)(VII), the Secretary of Housing and Urban Development; and

(V) clause (i)(VIII), the Secretary of Education.

(iii) the term “administering entity” means, with respect to the covered program described in—

(I) subclause (I), (II), (IV), (V), or (VI) of clause (i), the State agency responsible for the administration of the program in a State;

(II) clause (i)(III), the Secretary of Health and Human Services;

(III) clause (i)(VII), the Secretary of Housing and Urban Development, a public housing agency, or another entity

that determines the eligibility of an individual for financial assistance; and

(IV) clause (i)(VIII), an institution of higher education involved.

AMENDMENT NO. 6

Page 79, line 23, strike out "Subparts 4 and 5 of part A of title" and insert in lieu thereof "Title".

AMENDMENT NO. 7

Page 85, line 6, insert "(1)" after the dash.

Page 85, after line 10, insert the following:

(2) Amounts appropriated under this subsection for a fiscal year which are not obligated by the end of such year shall remain available for obligation during the next fiscal year.

(3) If the amounts appropriated under this subsection for a fiscal year are insufficient to provide fully for reimbursement and payments under subsections (b) and (c) for the fiscal year—

(A) amounts shall first be obligated for purposes of making payments to States and State educational agencies under such subsections, and

(B) in obligating such amounts, amounts shall be allocated among the States and State educational agencies on an equal pro rata basis based on their costs under such subsections in providing public assistance and educational services, except as provided in paragraph (4).

(4)(A) If the amounts appropriated under this subsection for a fiscal year exceed 40 percent, but are less than 100 percent, of the amounts necessary to provide fully for reimbursement and payments under subsections (b) and (c) for the fiscal year, the subsection (b) percentage (as defined in subparagraph (B)) may exceed the subsection (c) percentage, so long as the subsection (c) percentage is not less than 40 percent.

(B) In subparagraph (A), the terms "subsection (b) percentage" and "subsection (c) percentage" mean the ratio (expressed as a percentage) of—

(i) the amounts obligated for purposes of making payments under subsection (b) or subsection (c), respectively, to

(ii) the amounts necessary to provide fully for reimbursement and payments under the respective subsection.

Page 86, line 15, insert "(1)" before "Subject".

Page 86, line 21, strike out the comma and all that follows up to the period on line 23.

Page 86, after line 23, insert the following new paragraph:

(2) The definitions and provisions of the Emergency Immigrant Education Act of 1984 (title VI of Public Law 98-

Sixth, the amendment makes clear that an administrative law judge's order in a discrimination case (unfair immigration-related employment practice) is a final agency order and is enforceable immediately unless appealed in accordance with provisions specified.

Seventh, the term "testimony taken" has been replaced by the word "evidence." This assures that an ALJ may consider records as well as oral testimony in a proceeding under the bill.

Eighth, the amendment provides for an alternative to NLRA procedures for seeking both judicial review of the ALJ's initial order, and court enforcement of the order if violated, as provided for in H.R. 3810. The new procedure works as follows: (1) once an ALJ issues his/her order, it becomes a final agency order, subject to judicial review on both law and facts, (2) any person aggrieved by that final order including the complainant, the respondent, or the special counsel, may seek judicial review of the ALJ's order in the U.S. Court of Appeals, under the substantial evidence rule. This appeal must be taken no later than 60 days after the entry of the final order, (3) if the appeal is taken within the 60 days, then the Court of Appeals will review the issues of fact and law and issue its own order. If it is an order to enforce the ALJ's order, then a violation of the court order is immediately enforceable in the Court of Appeals, as contempt of court, (4) if, however, the appeal of the ALJ's order is not taken within the 60 days, the aggrieved party loses his/her right to review of the ALJ order. Therefore, when a violation of that order occurs, an action for enforcement can be brought, either by the Special Counsel or the person filing the charge, in U.S. district court.

SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENT (SAVE)

AMENDMENT NO. 5

The fifth amendment adopted by the Committee is related to the SAVE program.

SAVE is the acronym for the system required by H.R. 3810 for verification that an alien is eligible for benefits under certain entitlement programs. (AFDC, Medicaid, Unemployment Compensation, Food Stamps, Housing Assistance, and Title IV Educational Assistance).

The Committee is fully committed to the principle that only those individuals eligible to receive federal program benefits should receive them and that every effort be made to insure that noneligible individuals are prevented from wrongfully obtaining such benefits.

The Committee recognizes, however, that the relationship between an alien's legal status and his eligibility for benefits under various assistance programs is extremely complex, both because of the large variety of statuses that are available, and because eligibility rules differ significantly across programs. It is not the intention of this Committee to deny benefits to any currently eligible recipient. The Committee's concern with the SAVE provision arises from certain problems reported to have surfaced during various pilot projects operated by the Immigration and Naturalization Service.

The Education and Labor Committee is concerned with the mandatory nature of the SAVE provision of H.R. 3810, and has therefore amended section 121 of H.R. 3810, as reported by the Judiciary Committee in three respects: (1) by requiring reports from the General Accounting Office, (2) by providing the various program Secretaries with discretion to waive the required verification program under certain circumstances, and (3) clarifying certain procedural requirements for alien status verification for educational assistance programs.

Reports by the General Accounting Office

The SAVE Program has been in operation in limited form in pilot projects in a number of states and localities, particularly California, Colorado, Florida, Illinois, Houston, and New York City. It is the Committee's understanding that these pilot programs have experienced various problems. The Committee's amendment will require a report by the Comptroller General on the current pilot projects. Mr. Petri offered a perfecting amendment, which was unanimously accepted to assure that the report is to cover the effectiveness of the program as well as the problems shown by the various pilots. The report is to include recommendations for changes prior to the implementation of the system. The report must be filed with the Congress and the Commissioner of the Immigration and Naturalization Service by October 1, 1987.

During the implementation phase, the Committee also intends for the Comptroller General to monitor and analyze the implementation of such system, and report to the Congress and the respective program Secretaries by April 1, 1989 on such implementation, and to include any recommendations for changes in the system which may be appropriate.

Waiver authority in certain cases

The Committee amendment is intended to provide the various respective program Secretaries with the authority to waive the requirements of the computer verification implementation under certain circumstances. In fact, the program Secretaries are required to report to the appropriate Committees of the House and Senate on whether the application of the SAVE program to their programs is cost effective and whether there should be a waiver prior to the implementation of SAVE for their programs. The respective secretaries would be permitted to waive the requirements of this section if persuaded that the administering agency has in effect an alternative system of immigration status verification which is as effective and timely as that required under this section, or if the costs of administering the required system would exceed the estimated savings in program benefits. The waivers could be by program, state or geographic region, as appropriate.

The Committee is concerned that the computer data base may have serious flaws and would like to provide flexibility to the various Secretaries in implementing a verification system which would serve the intent of the program in benefit delivery. The Committee is further concerned that under certain circumstances the implementation and operation of the required verification system may not be cost effective. In examining a program to determine whether

for adult education, result in savings to state and local governments because they are already paying for such education. Thus, this amendment, by reducing these payments to states, would lower state and local government savings.

The Committee also amended the System for Alien Verification of Eligibility (SAVE), which would require a number of federal benefit programs to check with the Immigration and Naturalization Service as to the resident status of aliens applying for program benefits. These amendments would permit a program or jurisdiction not to use SAVE if waivers were granted by Department Secretaries. Waivers could be given if alternative verification systems were found to be as effective or if the administrative costs of SAVE exceeded any estimated savings. Without knowing more about SAVE and the extent to which waivers might be granted, the CBO estimate assumed that savings and costs would be approximately offsetting. If the cost effectiveness of SAVE could be measured accurately and waivers granted accordingly, however, these amendments would be likely to result in federal budgetary savings.

An amendment to the section concerning unfair immigration-related employment practices would make a number of procedural changes but would not significantly alter the costs of this provision. An amendment to Section 101, regarding unlawful employment of aliens, would delete the criminal penalty for employers repeatedly violating this provision and instead would increase civil penalties. CBO is unable to estimate the penalties that would be collected as a result of H.R. 3810 or of this amendment. The remaining amendments are estimated to have no significant effect on the costs of H.R. 3810.

If you wish further details on this estimate, please call me or have your staff contact Janice Peskin.

With best wishes,
Sincerely,

RUDOLPH G. PENNER, *Director.*

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 15, 1986.

Hon. PETER W. RODINO, JR.,
Chairman, Committee on the Judiciary, House of Representatives,
Rayburn House Office Building, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for H.R. 3810, the Immigration Control and Legalization Amendments Act of 1986.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes.
Sincerely,

RUDOLPH G. PENNER, *Director.*

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE, JULY 15, 1986

1. Bill number: H.R. 3810.

2. Bill title: Immigration Control and Legalization Amendments Act of 1986.

3. Bill status: As ordered reported by the House Committee on the Judiciary, June 25, 1986.

4. Bill purpose: H.R. 3810 makes major revisions and reforms to the Immigration and Nationality Act. Title I focuses on the control of illegal immigration. Part A of this title makes the employment of unauthorized aliens unlawful and establishes a special counsel to investigate and prosecute immigration-related unfair employment practices. Part B authorizes additional appropriations for the Immigration and Naturalization Service (INS) and the Executive Office of Immigration Review (EOIR) for fiscal years 1986 and 1987 to carry out the provisions of this act and calls for increased enforcement and adjudication activities. This part also makes it unlawful to transport any unauthorized alien into the United States and authorizes an appropriation of \$35 million for an immigration emergency fund. Part C requires a system to verify the immigration status of aliens applying for benefits under certain programs, and establishes procedures and provides for federal reimbursement of states' costs to implement and operate this system.

Title II of the bill governs the legalization of unauthorized aliens already in the country. It empowers the Attorney General to adjust the status of unauthorized aliens to that of lawfully admitted aliens eligible for temporary residence if they apply, meet certain conditions, can establish that they illegally entered the United States prior to January 1, 1982, and have been residing here continuously since then. After one year in temporary status, the Attorney General can adjust their status to that of permanent resident. In addition, it limits for a period of five years federal program benefits for which the authorized aliens granted resident status are eligible and authorizes appropriations for fiscal years 1987 through 1991 to reimburse states for the costs of providing public assistance to legalized aliens and educational services to legalized alien children.

Title III reforms existing law regarding legal immigration. Part A amends those provisions of the Immigration Act relating to non-immigrant workers (H-2 workers), provides legal resident status to certain agricultural workers, amends the procedures for obtaining approval of H-2 petitions, allows the Secretary of Labor to charge fees to recover the cost of processing applications for certification, and authorizes a program designed to recruit domestic workers for temporary labor. Part B changes certain numerical limitations, changes requirements for foreign students, amends the immigration laws regarding C-4 special immigrants, and establishes a visa waiver pilot program for certain visitors.

Titles IV and VI require a number of reports to the Congress, and Title V provides for assistance to state and local governments for the costs of incarcerating illegal aliens and certain Cuban nationals.

5. Estimated cost of the Federal Government:

[By fiscal year, in millions of dollars]

	1986	1987	1988	1989	1990	1991
Direct spending provisions:						
Required budget authority:						
Function 550		1	44	184	261	277
Function 570						
Function 600		(¹)	29	120	154	171
Function 650						
Estimated outlays:						
Function 550		1	44	184	261	277
Function 570		(¹)	(¹)	(¹)	5	16
Function 600		8	115	257	321	337
Function 650		(¹)	3	18	38	55
Amounts subject to appropriation action:						
Estimated authorization level:						
Function 500		25	25	26	27	27
Function 600		72	630	1,132	1,332	1,395
Function 750	434	557	442	423	427	407
Estimated outlays:						
Function 500		25	25	26	27	27
Function 600		4	177	866	1,268	1,352
Function 750		442	455	428	428	411
Total spending: Required budget authority/estimated authorization level	434	655	1,170	1,885	2,201	2,277
Estimated outlays		480	819	1,779	2,348	2,475
Estimated revenues		70	166	54	54	
Net budget impact: Estimated net increase or decrease (—) in the Deficit		410	653	1,725	2,294	2,475

¹ Less than \$0.5 million.**Basis of estimate:**

Control of Illegal Immigration (Functions 550, 600 and 750).— Title I of the bill authorizes additional appropriations for the INS of \$422 million in fiscal year 1986 and \$419 million in fiscal year 1987, and for the Executive Office of Immigration Review of \$12 million in 1986 and \$15 million in 1987. The funds authorized for the INS are intended to provide improved services, enhanced community outreach and inservice training of personnel. This authorization would provide for enhanced enforcement, including enforcement of employer sanctions, and additional processing of applications and adjudication, primarily resulting from the legalization and agricultural worker programs outlined by the bill. Because this estimate assumes enactment on approximately October 1, 1986, it assumes that none of the funds authorized for fiscal year 1986 will be appropriated, and therefore those authorizations will result in no outlays. While this title does not authorize appropriations for those agencies after 1987, CBO estimates that the additional activities required by this bill will result in additional costs of approximately \$220 million in 1988, declining to \$150 million in 1991.

This title also requires the appointment of a special counsel within the Department of Justice for Immigration-Related Unfair Employment Practices. The special counsel would be responsible for receiving and investigating complaints of such practices and bringing them, when appropriate, before specially trained administrative law judges. Based on information from the Immigration and

Naturalization Service and the National Labor Relations Board, CBO expects this process to cost \$2 million in 1987 and 1988 and \$3 million in later years. The bill does not, however, authorize appropriations for this activity. Also required would be a system to validate the Social Security account numbers of all individuals employed in the United States. Employers would be required to submit each account number and receive a validation code. CBO estimates that approximately 80 million numbers would be submitted for validation each year. Based on information from the Social Security Administration, CBO estimates that this system would cost about \$130 million each year, beginning in 1988, with slightly higher costs in the first year. Both of these estimates are highly uncertain.

Title I authorizes an appropriation of \$35 million for an immigration emergency fund to be used for increased enforcement of the nation's immigration laws and for providing assistance to states and localities facing major immigration problems. CBO does not show an increase in outlays as a result of this fund, because spending is prohibited unless the President declares an immigration emergency, and it is impossible to predict when, or whether, such a declaration would be made.

The bill requires that the immigration status of aliens applying for a number of federal benefit programs be verified with the INS beginning no later than October 1, 1988. All state costs would be fully reimbursed by the federal government. CBO estimates that this provision would have no significant budgetary effect in 1987 or in 1988, would reduce outlays by \$25 million in 1989, and by \$20 million a year thereafter. These savings are very uncertain. The only tests of the verification system have been for the Unemployment Compensation program in a few states, where savings were found to be modest. The CBO estimate for the Unemployment Compensation program is based on these test results. Savings for the Aid to Families with Dependent Children, Medicaid, and Food Stamp programs are based on the number of cases found to be in error because of alien status, as reported in the quality control data systems. This estimation procedure underestimates savings. Costs are based on information provided by the INS and assume in most cases a statewide system of checking. These costs are underestimated because some states with country-run programs would have higher costs. Also, there is expected to be considerable adjudication, because the INS data are out-of-date and incomplete; this cost cannot be estimated.

The following table summarizes the costs of Title I.

ESTIMATED BUDGET IMPACT—CONTROL OF ILLEGAL IMMIGRATION (FUNCTIONS 550, 600, AND 750)

[By fiscal year, in million of dollars]

	1986	1987	1988	1989	1990	1991
Authorization:						
Immigration and Naturalization Service ¹	422	419	.....	.....	.....	.....
Executive Office of Immigration Review ¹	12	15	.....	.....	.....	.....
Immigration emergencies		35	.....	.....	.....	.....
Status verification ²		(³)	(³)	-15	-10	-10
Other estimated costs ⁴		2	351	317	311	286

ESTIMATED BUDGET IMPACT—CONTROL OF ILLEGAL IMMIGRATION (FUNCTIONS 550, 600, AND 750)—Continued

[By fiscal year, in millions of dollars]

	1986	1987	1988	1989	1990	1991
Total estimated authorizations.....	434	471	351	302	301	276
Estimated outlays.....		371	364	297	292	270

¹ It is assumed that enactment of this bill will not allow time for funds to be appropriated in fiscal year 1986; therefore, no outlays are shown for the 1986 authorizations.

² The bill authorizes such sums as may be necessary for the INS. This estimate also includes CBO's estimate of costs and savings in functions 550 and 600.

³ Less than \$0.5 million.

⁴ This amount reflects estimated costs for which no authorizations are provided in the bill. These costs are largely for INS enforcement and processing activities after 1987, and for the required system for validating an individual's Social Security number.

Legalization (Functions 550, 570, 600, and 650).—By legalizing some unauthorized aliens currently in the United States, Title II would increase federal outlays in functions 550 (Health, including Medicaid), 570 (Medicare), 600 (Income Security), and 650 (Social Security). First, the provisions that legalize unauthorized aliens would entitle the aliens to receive benefits after five years from a number of federal assistance programs. Such programs as Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), Medicaid, and Food Stamps now require recipients to be citizens or have resident status. Because the provisions of the bill preclude most aliens granted resident status from receiving any program of federal financial assistance based on "financial need," Medicaid, and Food Stamps for a period of five years, federal outlays for these programs generally do not begin until fiscal year 1992, beyond our estimating period. An exception is made in the bill for the aged, blind, and disabled and for medical assistance provided to children under 18 years of age, pregnant women, and those in need of emergency services. Hence, the cost estimate does show increased federal outlays for SSI, Medicaid, and Food Stamps beginning in fiscal year 1987. In addition, in other programs that are not based on "financial need," such as Disability Insurance (DI), some legalized aliens who would not have collected benefits would now be expected to do so.

Second, Title II provides an authorization for the appropriation of such sums as may be necessary in fiscal years 1987 through 1991 to reimburse states for 100 percent of the costs of public assistance to eligible legalized aliens. Aliens granted resident status are eligible for five years. The bill also authorizes payments over the same five-year period to state education agencies to assist in providing educational services for the legalized alien children in elementary and secondary schools.

Added federal program outlays as a result of legalizing unauthorized aliens under Title II of the bill as shown in the table below. These added outlays are estimated to be \$8 million, \$272 million, \$1,143 million, \$1,646 million, and \$1,777 million in fiscal years 1987 through 1991, respectively.

This estimate is very uncertain, particularly because of the three factors discussed below. First, this estimate includes federal outlays for the grants to states that are large enough to cover the full estimated costs to states for public assistance to the legalized aliens and education services for the legalized alien children. Less than

the full costs, however, might be appropriated. Second, this estimate depends importantly on the number of unauthorized aliens in the United States, for which little hard evidence exists. It has been generally accepted that there were 3 to 6 million unauthorized aliens in the United States in the late 1970s. The CBO estimate uses 4.5 million aliens in 1977, the midpoint of the range. Even less is known about how the numbers of unauthorized aliens in the United States may have changed in recent years, although anecdotal evidence indicates there has been some net inflow. Based on conversations with persons knowledgeable about the unauthorized alien population, CBO assumes a net increase of 150,000 in each year beginning in 1980. In 1986, then, CBO assumes that there are 5.6 million unauthorized aliens in the United States.

Of the 5.6 million unauthorized aliens, CBO estimates that 40 percent have resided continuously in the United States since January 1, 1982, making them eligible for legalization under this bill. This figure is based on percentages from Immigration and Naturalization Service (NS) studies, which have been adjusted upward to reflect the assumption that some unauthorized aliens are aware of the possibility of legalization because of legislative activity in recent years. Among those eligible, we assume—again based on conversation with experts—that approximately 60 percent would apply for and be granted resident status. The resulting number of unauthorized aliens who would be granted resident status is estimated to be 1.4 million.

Finally, the number of legalized aliens who would qualify for government assistance programs is uncertain. In large part, this reflects a lack of data on the economic and demographic characteristics of unauthorized aliens—for example, their employment status and wages or their age and marital status. In developing the estimates of numbers of legalized aliens who would receive benefits from government programs, CBO assumes that the unauthorized aliens would have to show at the time of their applicant for residency that they had not been nor would they be likely to be “public charges,” as specified in Section 212 of the Immigration and Nationality Act. However, the bill would allow resident status to an unemployed alien if that alien could demonstrate a history of employment without reliance on public cash assistance. Thus, at the time the aliens would become residents, most would presumably be working. Over time, however, they could be expected to resemble the U.S. population as to receipt of benefits from entitlement programs. By 1990, CBO assumes that the percentage of unauthorized aliens receiving government benefits would resemble that of the U.S. population for similar age, sex, ethnic origin, and income groupings. In the interim years, CBO assumes that a growing fraction of potential eligibles would in fact receive benefits; 5 percent in 1987, 30 percent in 1988, and 75 percent in 1989.

In addition to the general basis of these estimates, each individual program estimate entailed specific procedures and assumptions. The details for each program are discussed below.

The SSI program provides benefits to aged, blind, and disabled persons. Benefit levels are set by the federal government, which pays the full cost of the program, although states may supplement federal benefits and most do. Under this bill, legalized aliens would

be eligible to receive SSI upon confirmation of residency status. Costs to the federal government are estimated to rise from an insignificant amount in 1987 to \$116 million in 1991. CBO's cost estimate is based on a reciprocity rate of 0.90 percent of the alien population for the aged and 0.94 percent for the blind and disabled. The reciprocity rate for the aged is based on Census data which show 1.80 percent of illegal aliens to be aged, an assumed income eligibility of 100 percent, and a participation rate for the eligible of 50 percent. The reciprocity rate for the blind and disabled is based on the current reciprocity rate for the population. The aliens are estimated to receive the full SSI basic benefit, or \$4,131 in 1987.

Food stamps are issued to eligible low-income households. Benefits (and approximately one-half of state administrative expenses) are funded by the federal government. As with AFDC, most legalized aliens could not receive food stamps until 1992, although legalized aliens who received SSI could also receive food stamps. Food stamp costs are estimated to be insignificant in 1987, rising to \$6 million in 1991. This figure is based on the estimated number of aliens added to the SSI rolls and a food stamp participation rate of 45 percent, the estimated current rate for SSI recipients. Average annual benefits per person in 1987 are estimated to be \$444.

The Unemployment Compensation program provides weekly cash benefits to workers who are involuntarily unemployed and who have had at least a moderate amount of work experience during a one-year period prior to losing their jobs. Under this bill, Unemployment Compensation costs for newly legalized alien workers are estimated to rise from \$3 million in 1987 to \$115 million in 1991. This estimate is based on several assumption for newly legalized alien workers. Consistent with recent labor force data on young Hispanics, CBO assumes that 80 percent of these workers would participate in the labor force, a higher rate than the average of the U.S. population. Because most probable work in service industries, which are less prone to cyclical unemployment, and because even-low-wage jobs in this country probably appear attractive when compared to those in the country of origin, CBO assumes that the newly-legalized population would have unemployment rates one percentage point lower than those in effect for the rest of the U.S. population. Further, assuming, as some evidence indicates, that these individuals' earnings are about 60 percent of those of comparable U.S. production or nonsupervisory workers (and assuming a 50 percent wage replacement rate), CBO estimates that the average weekly benefit amount for these workers would be about \$97 in 1987, one-fourth lower than that for the remainder of the population.

The Disability Insurance (DI) program covers persons who are totally disabled (whose disability is expected to last at least 12 months or result in death) and who have sufficient work histories in covered employment. Costs in DI of the legalized aliens are estimated to rise from an insignificant amount in 1987 to \$54 million in 1991. Because the evidence indicates that unauthorized aliens are relatively young on average, they would be less likely to be disabled than the U.S. population as a whole. Also, because they have been in the United States for relatively short periods of time, they might not qualify for DI, which requires for most workers covered

earnings during 20 out of the last 40 calendar quarters. For all of these reasons, their DI reciprocity rate would be less than that of the U.S. population; CBO estimates the rate to be about 0.1 percent in 1987, with this rate rising to about 0.7 percent in 1991. Their benefit levels would also be less, reflecting lower than average wages and shorter work histories. The CBO estimates average benefits to be about \$4,300 in 1991.

The Medicaid program provides health care coverage to recipients of AFDC and SSI and to others who may qualify as "medically needy." Under the bill, Medicaid would be provided to aliens on SSI and to children, pregnant women, and emergency cases who could meet Medicaid's eligibility criteria. Costs are estimated to rise from \$1 million in 1987 to \$231 million in 1991. Medicaid beneficiaries are based on numbers of aliens estimated to receive SSI and numbers estimated to receive AFDC who would be children, pregnant women, or in need of emergency services, with some increase for the medically needy. Benefits are current averages per SSI or AFDC enrollee, adjusted to 1987 and later.

Costs in the Medicare program, which provides health care coverage to the aged and disabled covered by Social Security, would rise to \$16 million by 1991. These costs would be for those aliens who would receive DI.

Reimbursements to states for public assistance costs are estimated to cost \$2 million in 1987 and \$527 million in 1991. These reimbursements are based on costs in state and local General Assistance (GA) programs. These programs are fully-funded by states and localities and provide benefits to low-income persons and families who do not qualify for the federally-funded cash welfare programs. GA provides both cash payments and medical coverage. Two groups of aliens would qualify for GA: those who would never be eligible for federal welfare programs (for example, low-income working two-parent families with children, and non-aged, non-disabled couples or single persons without children) and those who would be made ineligible for AFDC by the bill for a period of five years.

Among the first group, CBO estimates that 1.3 percent of the aliens would receive an average annual cash GA benefit of \$1,725 in 1987. This estimate is based on current reciprocity rates and benefit levels in GA programs. Among the second group, CBO's estimate for families who would have qualified for AFDC is based on the assumption that 52 percent of the aliens given resident status would be married men and women, reflecting demographic data on unauthorized aliens, which show about 79 percent to be adults and the majority to be young and male, and marital rates in the United States. Of the married men and women, 4.5 percent of those not of Spanish origin and 17.0 percent of those of Spanish origin are estimated to receive AFDC. These rates of AFDC reciprocity are those which currently exist in the program. The average annual cash benefit for these alien families is estimated to be \$2,150 in 1987. These aliens would also receive medical GA. Their average annual medical benefits are estimated to be \$715 in 1987.

Reimbursements to states for education services are estimated to cost \$1 million in 1987 and \$712 million in 1991. This cost assumes a full appropriation of funds to cover total costs of educating the eligible alien children. Of the total legalized alien population, 15

percent—or about 200,000—are estimated to be children of school age. Average per pupil costs were \$3,086 during the 1983–1984 school year, the latest data available. CBO assumes that this 1983–1984 per pupil cost would be used in calculating reimbursements to the states in 1987. This is consistent with current procedures in Chapter I education aid to disadvantaged children. Outlays reflect a spending pattern of 2 percent in the first year, 77 percent in the second year, and 21 percent in the third year.

The table on the following page summarizes the estimated costs associated with Title II.

Agricultural Worker Provisions (Function 500, 550, 600, and 650).—Title III of the bill provides for the availability of temporary agricultural workers and for the legalization of certain illegal alien workers recently employed in agriculture. CBO estimates the agricultural worker provisions would increase federal outlays by \$56 million in 1987, rising to \$324 million by 1991.

The bill authorizes such sums as may be necessary to enable the Department of Labor (DOL) to make determinations and issue certifications under a new H-2A worker program, targeted at agriculture. The H-2 worker program allows foreign workers to enter the United States temporarily to work in jobs for which employers cannot find domestic workers. In making this estimate, it is assumed that the combination of employer sanctions and a strengthened INS would act as effective deterrents to the hiring of illegals to perform agricultural labor. It is further assumed that the H-2A worker program would expand to fill the otherwise unmet demand for agricultural labor, thereby increasing the administrative costs of DOL.

According to staff from the Department of Agriculture (USDA), if employer sanctions were effectively enforced, growers would need between 250,000 and 500,000 guest workers. Because the CBO assumes that about 250,000 illegal alien workers in agriculture would be legalized under the special agricultural worker provision discussed below, the number of H-2A workers could range up to 250,000 guest workers. The DOL is currently receiving about 800 applications per year for H-2 agricultural workers, and each application requests an average of 25 workers. Administrative costs were about \$3 million in 1985, or \$3,750 per application, for the agricultural part of the H-2 worker program, and they are estimated to increase by about 5 percent per year.

Currently, those illegal immigrants who work in agriculture are located primarily in the West and Southwest, while most H-2 workers are employed in the East. Since western agricultural concerns tend to be far larger than eastern, it is assumed that future applications would be for about 40 workers on average. Using a projected cost per application of about \$4,100 in 1987, CBO estimates that 1987 administrative costs would be \$13 million. This figure is based on an estimated 3,125 applications: 125,000 guest workers—the midpoint of the estimated range noted above—and an estimated 40 workers per application.

ESTIMATED BUDGET IMPACT—LEGALIZATION (FUNCTIONS 550, 570, 600, AND 650)

(By fiscal year, in millions of dollars)

	1987	1988	1989	1990	1991
SSI (function 600):					
Required budget authority.....	(¹)	23	83	103	116
Estimated outlays.....	(¹)	23	83	103	116
Food stamps (function 600):					
Estimated authorization level.....	(¹)	1	4	6	6
Estimated outlays.....	(¹)	1	4	6	6
Unemployment compensation (function 600):					
Required budget authority.....					
Estimated outlays.....	3	47	88	116	115
Disability insurance (function 650):					
Required budget authority.....					
Estimated outlays.....	(¹)	3	18	38	54
Medicaid (function 550):					
Required budget authority.....	1	39	156	218	231
Estimated outlays.....	1	39	156	218	231
Medicare (function 570):					
Required budget authority.....					
Estimated outlays.....	(¹)	(¹)	(¹)	5	16
Reimbursement of State public assistance costs (function 600):					
Estimated authorization level.....	2	96	370	507	527
Estimated outlays.....	2	96	370	507	527
Payments to States for education costs (function 600):					
Estimated authorization level.....	70	516	690	717	754
Estimated outlays.....	1	63	423	653	712
Subtotal: Direct spending provisions:					
Required budget authority.....	1	62	239	321	347
Estimated outlays.....	4	112	345	480	532
Subtotal: Amounts subject to appropriation action:					
Estimated authorization level.....	72	613	1,064	1,230	1,288
Estimated outlays.....	4	160	798	1,166	1,245
Total:					
Estimated authorization level/ required budget authority.....	73	675	1,303	1,551	1,635
Estimated outlays.....	8	272	1,143	1,646	1,777

¹ Less than \$0.5 million.

In addition, the bill requires the federal government to establish a program to (a) recruit domestic workers to perform services that might otherwise be performed by temporary foreign nonimmigrant laborers, and (b) monitor the terms and conditions under which temporary agricultural workers are employed in the United States. A total of \$10 million per year beginning in 1987 is authorized for these purposes.

The estimated budget impact of the temporary agricultural worker program in H.R. 3810 is summarized in the following table.

ESTIMATED BUDGET IMPACT—TEMPORARY AGRICULTURAL WORKERS (FUNCTION 500)

(By fiscal year, in millions of dollars)

	1987	1988	1989	1990	1991
H-2A Worker Program:					
Estimated authorization level.....	13	13	14	15	15
Estimated outlays.....	13	13	14	15	15
Domestic worker recruitment:					
Authorization level.....	10	10	10	10	10
Estimated outlays.....	10	10	10	10	10

The bill's provision for special agricultural workers would establish legal status for agricultural workers who could demonstrate that they had worked at least 60 days in agricultural employment during the period from May 1, 1985 to May 1, 1986. Since these workers would be provided with legal resident status, federal outlays for entitlement program benefits would rise by an estimated \$5 million in 1987 and \$295 million in 1991.

Workers covered under the special agricultural workers provision are estimated to total about 250,000. This figure was derived by adjusting the number of farm workers upward for turnover during the year and downward for the 60-day work requirement. Further, it is assumed that about 25 percent of farm workers are illegal aliens and that 60 percent would come forward to apply for and be accepted as legal residents. CBO was unable to determine whether the provisions designed to allow additional special agricultural workers beginning in 1990 in the event of a worker shortage would increase the number granted resident status in the future.

Most of the additional entitlement spending would occur in means-tested benefit programs such as AFDC, Medicaid, SSI, and Food Stamps, although the program with the largest increase would be Unemployment Compensation. Unemployment Compensation benefits are estimated to increase from \$5 million in 1987 to \$61 million by 1991. These estimates are based on the assumptions that unemployment rates of agricultural workers are about 75 percent higher than the national average, agricultural wages are lower than overall average wages, and that the average weekly benefit would be about \$97 in 1987. AFDC costs are expected to increase as the number of recipient families is estimated to rise by about 14,000 persons by 1990. Medicaid outlays associated with the increases in AFDC and SSI beneficiaries are estimated to rise by about \$5 million in 1988 and \$53 million by 1991.

Title III also specifies that a commission would be established that would examine the impacts of the special agricultural worker provisions on wages, working conditions, and issues. The CBO estimates that the costs of the commission, including personnel and other non-labor expenses, would be about \$2 million annually over the next five years.

The table on the following page summarizes the estimated costs associated with the special agricultural worker provisions.

Reports to the Congress (Function 750).—Title IV requires the preparation of a number of Presidential reports. These include a comprehensive triennial report on admissions under the Immigration and Nationality Act and the impact of those admissions, reports on unauthorized alien employment and discrimination in employment, biennial reports on the implementation of the temporary agricultural worker program, two reports on the legalization program and its impact, and a report on the visa waiver pilot program. Title VI requires the Attorney General to prepare a report for the Congress on the resources required by the INS to carry out

its enforcement and service responsibilities. The cost of these reports is assumed to be included in the amounts authorized for the INS.

In addition, the bill requires the Civil Rights Commission to monitor the implementation and enforcement of the employer sanctions provisions and investigate any allegations of unlawful discrimination due to these provisions. The Commission is to report as to whether implementation and enforcement of these provisions has resulted in a pattern of unlawful discrimination. Implementation of this provision is expected to cost approximately \$1 million each year.

State and Local Assistance for Incarceration of Illegal Aliens and Certain Cuban Nationals (Function 750).—Title V would require the Attorney General to reimburse state and local governments for the costs of imprisoning these aliens and Cuban nationals convicted of felonies and for their pre-trial and post-trial detention. Appropriations are authorized for such sums as are necessary to carry out this provision. CBO estimates that reimbursements would be required for approximately 6,000 prisoners at an average cost of about \$14,000 per prisoner-year in 1987, rising to \$17,000 per year by 1991.

ESTIMATED BUDGET IMPACT—INCARCERATION COSTS (FUNCTION 750)

[By fiscal year, in millions of dollars]

	1987	1988	1989	1990	1991
Estimated authorization level	85	90	95	100	105
Estimated outlays	70	90	95	100	105

Revenues.—CBO assumes that the Attorney General would collect a fee of \$100 for each application submitted by an alien for permanent or temporary residency under the legalization provisions in Title II. CBO estimates that 1.8 million aliens would apply for legal temporary residency—0.6 million in 1987 and 1.2 million in 1988. In 1988 through 1990, the 1.4 million aliens granted temporary residency would apply for permanent residency. The special agricultural workers would also apply for legalization during 1987 and 1988: an estimated 0.1 million in 1987 and 0.2 million in 1988. With a fee of \$100 per application, CBO estimates that the government would receive a total of \$344 million over the four years from legalization application fees.

ESTIMATED BUDGET IMPACT—SPECIAL AGRICULTURAL WORKERS (FUNCTIONS 500, 550, 600, and 650)

[By fiscal year, in millions of dollars]

	1987	1988	1989	1990	1991
AFDC (function 600):					
Required Budget Authority	(1)	6	25	35	36
Estimated Outlays	(1)	6	25	35	36

ESTIMATED BUDGET IMPACT—SPECIAL AGRICULTURAL WORKERS (FUNCTIONS 500, 550, 600, and 650)—Continued

[By fiscal year, in millions of dollars]

	1987	1988	1989	1990	1991
SSI (function 600):					
Required Budget Authority	(¹)	(¹)	16	20	23
Estimated Outlays	(¹)	(¹)	16	20	23
Food stamps (function 600):					
Estimated authorization level	(¹)	5	23	32	33
Estimated Outlays	(¹)	5	23	32	33
Unemployment compensation (function 600):					
Required Budget Authority					
Estimated Outlays	5	39	59	61	61
Disability insurance (function 650):					
Required Budget Authority					
Estimated Outlays	(¹)	(¹)	(¹)	(¹)	1
Medicaid (function 550):					
Required Budget Authority	(¹)	5	35	50	53
Estimated Outlays	(¹)	5	35	50	53
Reimbursement of State public assistance costs (function 600):					
Estimated authorization level	(¹)	12	59	84	88
Estimated Outlays	(¹)	12	59	84	88
Agricultural worker commission (function 500):					
Estimated authorization level	2	2	2	2	2
Estimated Outlays	2	2	2	2	2
Subtotal: Direct spending provisions:					
Required Budget Authority	(¹)	11	76	105	112
Estimated Outlays	5	50	135	166	174
Subtotal: Amounts subject to appropriation action:					
Estimated authorization level	2	19	84	118	123
Estimated Outlays	2	19	84	118	123
Total:					
Estimated authorization authority level/required Budget authority	(¹)	30	160	222	235
Estimated Outlays	5	69	219	284	297

¹ Less than \$0.5 million.

In addition, the bill allow the Secretary of Labor to impose a fee on employers importing temporary agricultural workers to recover the costs of processing applications for certification. It has not yet been determined whether the Secretary of Labor would impose such a fee and CBO is unable at this time to estimate how much money would be collected as a result of this fee. Also, the bill permanently exempts employers from paying Federal Unemployment Tax Act taxes on wages paid to H-2 agricultural workers. This provision has a negligible revenue effect.

Part B of title I increase penalties for immigration-related violations and Part A outlines employer penalties for illegal employment of unauthorized aliens. No estimate can be made of the fines that would be collected by the federal government as a result of these sections.

In addition to the above effects on federal revenues, there are potential effects on individual income tax revenues and social insurance contributions. Revenues would increase if some of the aliens who are not having taxes withheld from their wages at present were to have taxes withheld as a result of this legislation. Revenues would decrease if aliens who currently have taxes withheld

and are entitled to refunds that they do not claim would claim refunds as a result of this bill. Given the uncertainties concerning characteristics of illegal aliens, and rough estimates showing the two effects above to be approximately offsetting, CBO shows no effect of the bill on these revenue sources.

ESTIMATED REVENUE EFFECT

[By fiscal year, in millions of dollars]

	1987	1988	1989	1990	1991
Revenues from application fees.....	70	166	54	54	.....

6. Estimated cost to State and local governments: By legalizing certain unauthorized aliens currently residing in the United States, this bill could have sizable effects on state and local government budgets. Unauthorized aliens are not eligible for welfare programs that are partially- or fully-funded by states and localities. When legalized, these aliens would be eligible for such programs—immediately in the case of state programs and after five years in the case of programs financed by federal and state governments jointly. The special agricultural workers would be eligible for federal and state programs immediately. During the estimation period, however, states and localities would have no added costs under CBO's assumptions. They would, in fact, experience budgetary savings to the extent funds were appropriated to cover their public assistance, education, and imprisonment costs, as authorized in the bill. After 1991, however, when the public assistance and education reimbursements were no longer available, states and localities would experience increase costs.

As shown in the table, public assistance costs would be zero to the extent the authorized reimbursements covered them in full, as CBO has assumed. The full amounts of any reimbursements for education services are estimated to result in state and local savings. States were required to educate illegal alien children by the Supreme Court in *Plyler vs. Doe* (June 15, 1982). Finally, any reimbursements for costs of incarcerating illegal aliens currently borne by states and localities would also result in budgetary savings.

[By fiscal year, in millions of dollars]

	1987	1988	1989	1990	1991
Public assistance.....					
Education assistance.....	-1	-63	-423	-653	-712
Assistance for imprisonment costs.....	-70	-90	-95	-100	-105
Total estimated State and local outlays.....	-71	-153	-518	-753	-817

A number of factors made these estimates uncertain. For purposes of this estimate, it is assumed that funds for reimbursements to states would be appropriated in full. If less than this amount were appropriated, states and localities would have lower savings or even experience budgetary costs. On the other hand, with a full appropriation, savings to states and localities would be higher than

CBO has estimated. Certain current expenditures by states and localities would be covered under the grant: free health care provided to unauthorized aliens in public hospitals, assistance to Cuban and Haitian entrants, and any public assistance being received illegally by unauthorized aliens. However, CBO does not have sufficient information to estimate these potential savings.

In addition, other titles of the bill could affect state and local budgets. If the provisions of the bill that provide for employer sanctions and other means of reducing the flow of unauthorized aliens into the United States are effective, there would be some associated savings to state and local governments. For example, there would be fewer alien children to educate. The CBO cost estimate does not include such savings, given the uncertainties concerning flows of unauthorized aliens into the United States and the potential effectiveness of the bill's sanction provisions.

7. Estimate comparison: None.

8. Previous CBO estimate: On August 20, 1985, CBO prepared a cost estimate for S. 1200, the Immigration Reform and Control Act of 1985, as ordered reported by the Senate Committee on the Judiciary, July 30, 1985. The estimated budget impact of S. 1200 is shown below:

(By fiscal year, in millions of dollars)

	1986	1987	1988	1989	1990
Estimated net increase or decrease (—) in the deficit.....	-25	99	126	341	328

S. 1200 authorized total appropriations for the INS of \$840 million in 1987 and \$830 million in 1988. CBO's estimate of the impact of that authorization was the increase over the existing baseline funding level for INS. The Senate bill did not authorize appropriations for the Executive Office of Immigration Review.

The legalization provisions of H.R. 3810 and S. 1200 also differ significantly. First, in H.R. 3810, unauthorized aliens qualify for residence status if they arrived in the United States before January 1, 1982. In S. 1200, they qualify if they arrived before January 1, 1980. Consequently, the House bill would make more aliens eligible for resident status—1.4 million versus 0.6 million—and would result in higher outlays for state assistance and federally-funded income security and health programs. The House bill also legalizes unauthorized aliens who worked in agriculture between May 1, 1985 and May 1, 1986, adding another 0.25 million aliens who would receive federal program benefits immediately. Second, S. 1200 provides no education assistance to states. Third, S. 1200 precludes receipt of federal program benefits based on "financial need" for six years, instead of H.R. 3810's five years, and does not except the aged and disabled or children, pregnant women, and medical emergencies from the prohibition on receipt of federal benefits. Fourth, S. 1200 authorizes a capped entitlement for payments to states of \$300 million a year for the first two years and \$600 million a year for the next four years, beginning with the year in which the application period ends, compared to authorization of

full reimbursement for five years in H.R. 3810. Finally, S. 1200 slows the legalization process by an estimated two years by requiring a Legalization Commission to find that more effective enforcement measures had been instituted with adequate resources to curtail the entry and stay of unauthorized aliens before legalization could proceed.

9. Estimate prepared by: Janice Peskin, Marjorie Miller, Linda Radey, Paul Cullinan, Lynne Davidson, Julia Isaacs, and Anne Manley.

10. Estimate approved by: C.G. Nuckels, for James L. Blum, Assistant Director for Budget Analysis.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the Committee estimates that this bill will not have a significant inflationary effect on prices and costs in the operation of the national economy.

OVERSIGHT

No oversight findings have been presented to the Committee by the Committee on Government Operations. The Committee's (Education and Labor) own findings are incorporated throughout the discussion above, "Analysis of Major Provisions."

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, except as shown below, are shown in part 1 of this report, filed by the Committee on the Judiciary on July 16, 1986. The differences between the bill as reported by the Committee and as reported by the Committee on the Judiciary are shown below using the following typographical devices (with "Judiciary" referring to the Committee on the Judiciary and "E&L" referring to the Committee on Education and Labor):

Existing law—

in which no change is proposed by Judiciary or E&L, printed in roman.

proposed to be omitted by both Judiciary and E&L, enclosed in black brackets, viz., [].

proposed to be omitted only by Judiciary (and not by E&L), printed in ~~linetype~~

proposed to be omitted only by E&L (and not by Judiciary), enclosed in black parentheses, viz., ().

New matter—

proposed to be inserted by both Judiciary and E&L, printed in *italic*.

proposed to be inserted only by Judiciary (and not by E&L), printed in *italic linetype*.

proposed to be inserted only by E&L (and not by Judiciary), printed in **boldface roman**.

IMMIGRATION AND NATIONALITY ACT

* * * * *

TITLE II—IMMIGRATION

* * * * *

CHAPTER 5—DEPORTATION; ADJUSTMENT OF STATUS

* * * * *

ADJUSTMENT OF STATUS OF CERTAIN ENTRANTS BEFORE JANUARY 1,
1982, TO THAT OF PERSON ADMITTED FOR LAWFUL RESIDENCE

SEC. 245A. (a) * * *

* * * * *

*(h) TEMPORARY DISQUALIFICATION OF NEWLY LEGALIZED ALIENS
FROM RECEIVING CERTAIN PUBLIC WELFARE ASSISTANCE.—**(1) * * **

* * * * *

*(3) TREATMENT OF CERTAIN PROGRAMS.—Assistance furnished
under any of the following provisions of law shall not be con-
strued to be financial assistance described in paragraph
(1)(A)(i):**(A) * * **

* * * * *

(G) Subparts 4 and 5 of part A of title Title IV of the Higher

* * * * *

CHAPTER 8—GENERAL PENALTY PROVISIONS

* * * * *

UNLAWFUL EMPLOYMENT OF ALIENS

SEC. 274A. (a) MAKING EMPLOYMENT OF UNAUTHORIZED ALIENS
UNLAWFUL.—*(1) * * **

* * * * *

*(5) USE OF STATE EMPLOYMENT AGENCY DOCUMENTATION.—For
purposes of paragraphs (1)(B) and (3), a person or entity shall be deemed
to have complied with the requirements of subsection (b) with respect to the
hiring of an individual who was referred for such employment by a State
employment agency (as defined by the Attorney General), if the person or
entity has and retains (for the period and in the manner described in sub-
section (b)(3)) appropriate documentation of such referral by that agency,
which documentation certifies that the agency has complied with the proce-
dures specified in subsection (b) with respect to the individual's referral.**(b) EMPLOYMENT VERIFICATION SYSTEM.—The requirements re-
ferred to in paragraphs (1)(B) and (3) of subsection (a) are, in the
case of a person or other entity hiring, recruiting, or referring an in-
dividual for employment in the United States, the requirements*

specified in the following three paragraphs (and, to the extent applicable, paragraph ~~(7)(C)~~ (6)(C):

(1) * * *

* * * * *

~~(6)~~ **TIME FOR COMPLIANCE.**—A person or entity has complied with the requirements of this subsection, with respect to the hiring of an individual, if the requirements of this subsection are first met not later than noon of the day following the day on which the individual is first employed by that person or entity.

~~(6)~~ (5) **LIMITATION ON USE OF ATTESTATION FORM.**—* * *

~~(7)~~ (6) **SOCIAL SECURITY ACCOUNT NUMBER VALIDATION SYSTEM.**—

* * * * *

(d) **PENALTIES.**—

(1) **CIVIL MONEY PENALTY FOR UNLAWFUL EMPLOYMENT, RECRUITING, OR REFERRAL.**—

(A) * * *

(B) **CRIMINAL PENALTY FOR PATTERN OR PRACTICE VIOLATIONS.**—In the case of a person or entity which has engaged in a pattern or practice of employment, recruitment, or referral in violation of paragraph (1)(A) or (2) of subsection (a), the person or entity shall be fined not more than \$1,000, imprisoned not more than six months, or both, for each violation.

(B) **CIVIL MONEY PENALTY FOR PATTERN AND PRACTICE VIOLATIONS.**—In the case of a person or entity which has engaged in a pattern or practice of employment, recruitment, or referral in violation of paragraph (1)(A) or (2) of subsection (a), the person or entity shall, after having been afforded notice and opportunity for an administrative hearing, be subject to a civil penalty of not less than \$3,000, and not more than \$10,000, for each unauthorized alien with respect to whom the violation occurred.

* * * * *

UNFAIR IMMIGRATION-RELATED EMPLOYMENT PRACTICES

SEC. 274B. (a) **PROHIBITION OF DISCRIMINATION BASED ON NATIONAL ORIGIN OR CITIZENSHIP STATUS**—

(1) **GENERAL RULE.**—It is an unfair immigration-related employment practice for a person or other entity to discriminate against any individual (other than an unauthorized alien) with respect to the hiring, or recruitment or referral for a fee, of the individual for employment or the discharging of the individual from employment—

(A) because of such individual's national origin, or

(B) in the case of a citizen or intending citizen (as defined in paragraph (3)), because of such individual's citizenship status.

(2) **EXCEPTIONS.**—Paragraph (1) shall not apply to—

(A) a person or other entity that employs three or fewer employees.

MINORITY VIEWS ON H.R. 3810

Although some of us supported and some of us opposed reporting H.R. 3810, we are in agreement that the bill contains some very problematic provisions that need to be addressed by the House.

ANTI-DISCRIMINATION PROVISION

We believe that the discrimination provisions will result in the creation of a new, costly bureaucracy that is unnecessary and duplicative.

The anti-discrimination provisions were included as part of the immigration bill because of the fears that employers, faced with the possibility of sanctions if they knowingly hired illegal aliens, would refuse to hire anyone who appeared to be "foreign." It is arguable whether the fear of discrimination because of sanctions is well founded; sanctions can be avoided by relatively simple steps to verify a workers's status. Moreover, a GAO study, updated in October 1985, concluded that in other countries where employer sanctions had been adopted, there was little or no evidence of discrimination against non-citizens.

If we are going to adopt tougher anti-discrimination measures, however, we see no sense in entrusting the enforcement of these provisions to a new office within the Department of Justice, rather than to the Equal Employment Opportunity Commission (EEOC). The bill prohibits two forms of employment discrimination: discrimination on the basis of citizenship status and discrimination on the basis of national origin. The prohibition of national origin discrimination is limited to employers of four to fourteen; employers of fifteen or more are already covered by Title VII of the Civil Rights Act of 1964. No Federal law now prohibits discrimination on the basis of citizenship status, although under EEOC guidelines citizenship requirements are already deemed violative of Title VII when they have the purpose or effect of discriminating against an individual on the basis of national origin.

If the bill's anti-discrimination provisions are adopted, national origin discrimination claims would be split between two agencies. For employers with four to fourteen employees, the national origin discrimination claims will be enforced by a new Special Counsel in the Department of Justice. For employers with fifteen or more employees, national origin discrimination claims would be enforced by the EEOC.

All citizenship discrimination cases are to be enforced by the new Special Counsel (no matter how large the employer). It is difficult to see any practical distinction between citizenship discrimination and national origin discrimination. The facts needed to prove discrimination on the basis of citizenship would stem from the same

source as those relied upon with respect to national origin discrimination claims.

We can see no reason why a new office of Special Counsel is necessary for the enforcement of these anti-discrimination provisions. With the EEOC, we already have an agency with the expertise and personnel for enforcement of national origin discrimination claims. Citizenship claims are so similar to national origin claims that they, too, should be enforced by the EEOC. The new office of Special Counsel is unnecessarily duplicative and expensive. Splitting enforcement of similar discrimination claims between two authorities may well give rise to disparate treatment for claimants with essentially identical grievances.

SPECIAL AGRICULTURAL WORKERS PROVISION

In addition to generally codifying the regulations governing the temporary foreign worker program under Section 215 of the Immigration and Naturalization Act, this bill creates a new class of workers called "Special Agricultural Workers" (SAWs). This group of workers is singled out for special treatment and is granted immediate permanent resident status and immediate eligibility for the full range of Federal benefits. Individuals who do not work in agriculture must wait five years before they are eligible for most Federal benefits. Likewise, undocumented workers who have not worked in agriculture have a continuous residence requirement that is thirty times as long as that of SAWs.

Inasmuch as the Republicans have had no opportunity to participate in the development of this provision, we believe our Minority Views to be an appropriate place to examine this provision carefully.

Who is eligible.—Any alien who can establish that he or she performed seasonal agricultural services in the United States for at least 60 man-days (a man-day is defined to mean any day during which an employee performs any agricultural labor for not less than one hour) during the twelve-month period ending May 1, 1986. The alien can be either inside or outside the U.S. when application is made.

Who receives the application.—The Attorney General shall designate qualified voluntary organizations, qualified State, local, community, farm labor organizations and associations of agricultural employers who have substantial experience in the preparation and submittal of applications for adjustment in status.

Proof of eligibility.—Government employment records, employer records, or organized labor's records may be used to establish proof of previous agricultural employment. Also, the Attorney General must establish procedures to credit work performed by an alien under an assumed name.

Penalties.—Knowing and willful falsification or concealment of material used in applications is subject to a fine and imprisonment of up to five years.

Numerical limitations.—None.

What are seasonal agricultural services.—This term is defined to mean the performance of field work related to planting, cultural practices, cultivating, growing and harvesting of fruits and vegeta-

bles and other perishable commodities as defined by the Secretary of Agriculture.

There is nothing in the legislation to require SAWs' continued employment in agriculture. An alien who applies for permanent resident status under the SAW provision may stay in this country and work in any occupation while his or her application is pending.

The bill requires that the Director of the Census Bureau, rather than the Attorney General, the Labor Department, or the Agriculture Department, "count" the number of SAWs during the year beginning in 1989. This number will be used as the base for determining the number of replenishment workers who may be admitted to work in agriculture in the following years.

The maximum number of replenishment workers declines by 5 percent less the number of SAWs the first year and by 10 percent the succeeding years until 1995 when the rate of decline reverts to 5 percent. However, before the percentage decrease occurs, there is a complicated formula in the bill which, limited by the cap, produces the number of admissible SAWs: the formula is, "shortage number" = (need of workers — supply of workers) ÷ a conversion factor.

The numbers of workers who would be granted permanent resident status under such a program are purely speculative. Guesses range from 200,000 to over 1,000,000.

It is our position that the immigration laws of our country should be applied equally. There should not be two sets of rules—one for agricultural workers and one for everyone else.

The Majority argued that any effort in committee to change these rules would kill immigration reform for yet another Congress, regardless of the merit of the rules or changes proposed. This Congress and this country suffer when we foreclose debate and amendment.

The consensus among the Republicans was that the Committee was not the place to work on this provision, but we certainly need to work on this section before it leaves the House.

CONCLUSIONS

We believe that a reasonable approach exists which would meet the needs of agricultural growers while at the same time treat all legalized aliens equitably. We intend to strive for a bill that provides for adequate protections to foreign workers, strong labor standards to domestic workers with enough flexibility to be responsive to growers needs in harvesting perishable crops.

JIM JEFFORDS.
BILL GOODLING.
TOM PETRI.
MARGE ROUKEMA.
STEVE GUNDERSON.
STEVE BARTLETT.
ROD CHANDLER.
JOHN R. MCKERNAN, Jr.
DICK ARMEY.
HARRIS W. FAWELL.

ADDITIONAL VIEWS OF MR. FAWELL AND MRS. ROUKEMA

We generally concur with the Minority views to H.R. 3810, the Immigration and Legalization Amendments of 1986, particularly as they pertain to the bill's anti-discrimination provisions. The mechanism established by H.R. 3810 is duplicative. Congress should only endow the Equal Employment Opportunity Commission (EEOC) with the authority to enforce the bill's citizenship discrimination and national origin discrimination measures.

The committee erred in its decision to strike the criminal penalty provisions of the Judiciary bill. As reported by the Judiciary Committee, H.R. 3810 establishes criminal penalties against those employers who engage in a "pattern or practice" of knowingly hiring, recruiting, or referring unauthorized aliens and for knowingly continuing to employ an alien after learning that he or she is unauthorized. Specifically, the employer would be subject to criminal penalties of not more than \$1,000 and/or imprisonment for not more than six months for each such violation.

The Judiciary bill also contains civil money penalties against those employers who hire, or recruit for a fee, for employment an alien knowing the alien is unauthorized with respect to such employment or who, after hiring any such alien, continue to employ the alien knowing the alien is unauthorized. These civil penalties are not less than \$1,000 and not more than \$2,000 for each unauthorized alien with respect to whom the violation occurred.

The committee agreed by an 11-9 vote to delete the criminal penalty provisions for those employers guilty of a general practice of violations under the Act and replace them with only civil penalties of not less than \$3,000 and not more than \$10,000 for each infringement of such "pattern and practice violations."

In defense of the amendment, Members claimed that the threat of criminal penalties would encourage employers to discriminate in hiring against Hispanics. We disagree. First, the criminal penalties are meant to hit the unrepentant employers who are indeed guilty of a general practice of illegally hiring undocumented aliens. The fear of criminal sanctions for such employers, with the possibility of imprisonment, will alone give effective notice to such employers that they cannot make it a "pattern and practice" to flaunt the new law. A lean immigration policy demands no less.

Second, H.R. 3810 includes provisions making it an unfair immigration-related employment practice to discriminate against an individual, other than an unauthorized alien, based on national origin or citizenship status. To enforce these anti-discrimination provisions, the bill creates a Special Counsel in the Justice Department, charged with the responsibility of investigating and prosecuting discrimination charges. Furthermore, the Education and Labor Committee approved an amendment which further strengthens the procedural aspects of the bill's anti-discrimination provisions.

Again, the criminal provisions of the Act are aimed only at those employers who are unrepentant and make it a general practice to knowingly hire undocumented aliens rather than follow the elementary provisions of the Act. It is pure legal sophistry to argue that such criminal sanctions aimed at such employers will force the average employer to knowingly breach the anti-discrimination portions of the Act. Criminal sanctions are only reserved for the employer who is able to accept civil monetary penalties as a way of "doing business."

The "most offensive provision of H.R. 3810 is the Special Agricultural Worker Program. This provision gives permanent resident status to illegal aliens who worked in agriculture for at least sixty days during the twelve-month period ending May 1, 1986. These workers would also be immediately eligible for entitlement benefits, such as food stamps, AFDC, Medicaid, SSI, and unemployment compensation.

The "compromise" program agreed to by labor and agricultural producers has two major problems. First, the program provides a separate legalization track for a selected group of illegal aliens. Whereas aliens not in agriculture must prove their presence in the U.S. since 1982 in order to obtain temporary resident status, these agricultural workers only have to have worked in agriculture for sixty days between May 1, 1985 and May 1, 1986 to receive permanent resident status. This dual legalization process is unfair and blatantly discriminates against nonagricultural workers. Agricultural workers will be eligible for federal benefits immediately; all others will have to wait five years.

Second, the program completely ignores the need to implement effective immigration laws. Instead of curbing immigration, this program will encourage more immigrants to come to the United States. This will be achieved in two ways. Because aliens working in agriculture can qualify immediately for permanent resident status, they may bring their immediate family into the country and all qualify for federal benefits.

Further undercutting an effective immigration policy is the bill's replenishment worker provisions. Once agricultural workers have obtained their permanent resident status, many may leave agriculture for other occupations, or public aid. The bill allows for replenishment workers if unforeseen circumstances lead to a shortage of workers. After working in agriculture for at least two years (at least sixty days each year), replenishment workers will be eligible for permanent resident status, and subsequently eligible for public aid. These workers could now bring immediate families to the U.S. and qualify for federal benefits.

This "compromise" agricultural worker program is disastrous. Although agricultural producers will benefit from this scheme, the welfare of the country will not. The Washington Post is right on target when it says: "Members will have to weigh the broad interests of the country against the specific desires of some groups. Unless a more reasonable compromise on agricultural workers is devised, reform is surely doomed."

We agree with this assessment of the agricultural worker program and urge our colleagues to oppose H.R. 3810 as long as this program remains intact. We are for immigration reform but H.R.

3810 with this overgenerous agricultural worker program, is not the solution. It is only the beginning of bigger immigration problems for our nation.

HARRIS W. FAWELL.
MARGE ROUKEMA.

IMMIGRATION CONTROL AND LEGALIZATION AMENDMENTS ACT OF 1986

AUGUST 5, 1986.—Ordered to be printed

Mr. ROSTENKOWSKI, from the Committee on Ways and Means,
submitted the following

REPORT

[To accompany H.R. 3810]

together with

DISSENTING VIEWS

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3810) to amend the Immigration and Nationality Act to revise and reform the immigration laws, and for other purposes, having considered the same, report those provisions of the bill within the jurisdiction of the Committee with amendments and recommend that the provisions as amended be agreed to.

The amendments (stated in terms of page and line numbers of the bill as reported by the Committee on the Judiciary) are as follows:

AMENDMENT NO. 1

Page 6, lines 4 and 5, strike out “(and, to the extent applicable, paragraph (7)(C))”.

Page 6, lines 7 and 8, strike out “AND VALIDATION OF SOCIAL SECURITY ACCOUNT NUMBER”.

Strike out “in the United States—” on page 6, lines 14 and 15, and all that follows down through page 7, line 7, and insert the following:

“in the United States by examining—

“(i) the individual’s United States passport,
or the individual’s unexpired foreign passport

if the foreign passport has an appropriate, unexpired endorsement of the Attorney General authorizing the individual's employment in the United States, or

“(ii) a document described in subparagraph (B) and a document described in subparagraph (C).

Page 7, line 9, strike out “clause (i) of this subparagraph” and insert “the preceding sentence”.

Page 7, line 15, strike out “clause (i)” and insert “such sentence”.

Strike out line 21 on page 10 and all that follows down through line 2 on page 12.

Page 160, after line 24, insert the following new subsection (and redesignate the succeeding subsection accordingly):

(b) **FEASIBILITY STUDY OF SOCIAL SECURITY NUMBER VALIDATION SYSTEM.**—The Secretary of Health and Human Services, acting through the Social Security Administration and in cooperation with the Attorney General and the Secretary of Labor, shall conduct a study of the feasibility and costs of establishing a social security number validation system to assist in carrying out the purposes of section 274A of the Immigration and Nationality Act, and of the privacy concerns that would be raised by the establishment of such a system. The Secretary shall submit to the Committees on Ways and Means and Judiciary of the House of Representatives and to the Committees on Finance and Judiciary of the Senate, within 2 years after the date of the enactment of this Act, a full and complete report on the results of the study together with such recommendations as may appear appropriate.

AMENDMENT NO. 2

Page 49, strike out lines 3 and 7, and redesignate the succeeding paragraphs accordingly.

Page 61, after line 14, insert the following new subsection:

(d) **GAO REPORT.**—

(1) **REPORT ON CURRENT PILOT PROJECTS.**—The Comptroller General shall—

(A) examine current pilot projects relating to the System for Alien Verification of Eligibility (SAVE) operated by, or through cooperative agreements with, the Immigration and Naturalization Service, and

(B) report, not later than October 1, 1987, to Congress and to the Commissioner of the Immigration and Naturalization Service concerning the effectiveness of such projects and any problems with the implementation of such projects, particularly as they may apply to implementation of the system referred to in subsection (c)(1).

(2) **REPORT ON IMPLEMENTATION OF VERIFICATION SYSTEM.** —The Comptroller General shall—

(A) monitor and analyze the implementation of such system,

(B) report to Congress and to the appropriate Secretaries described in subsection (c)(4)(D)(ii), by not later than April 1, 1989, on such implementation, and

(C) include in such report such recommendations for changes in the system as may be appropriate.

Page 61, line 7, strike "The amendments" and insert "Except as provided in paragraph (4), the amendments".

Page 61, after line 10, insert the following new paragraph (and redesignate the succeeding paragraph accordingly):

(4) USE OF VERIFICATION SYSTEM NOT REQUIRED FOR A PROGRAM IN CERTAIN CASES.—

(A) REPORT TO RESPECTIVE CONGRESSIONAL COMMITTEES.—With respect to each covered program (as defined in subparagraph (D)(i)), each appropriate Secretary shall examine and report to the appropriate Committees of the House of Representatives and of the Senate, by not later than April 1, 1988, concerning whether (and the extent to which)—

(i) the application of the amendments made by subsection (a) to the program is cost-effective and otherwise appropriate, and

(ii) there should be a waiver of the application of such amendments under subparagraph (B).

(B) WAIVER IN CERTAIN CASES.—If, with respect to a covered program, the appropriate Secretary determines, on the Secretary's own initiative or upon an application by an administering entity and based on such information as the Secretary deems persuasive (which may include the results of the report required under subsection (d)(1) and information contained in such an application), that—

(i) the appropriate Secretary or the administering entity has in effect on alternative system of immigration status verification which—

(I) is as effective and timely as the system otherwise required under the amendments made by subsection (a) with respect to the program, and

(II) provides for at least the hearing and appeals rights for beneficiaries that would be provided under the amendments made by subsection (a), or

(ii) the cost of administration of the system otherwise required under such amendments exceed the estimated savings,

such Secretary may waive the application of such amendments to the covered program to the extent (by State or other geographic area or otherwise) that such determinations apply.

(C) **BASIS FOR DETERMINATION.**—A determination under subparagraph (B)(ii) shall be based upon the appropriate Secretary's estimate of—

(i) the number of aliens claiming benefits under the covered program in relation to the total number or claimants seeking benefits under the program,

(ii) any savings in benefit expenditures reasonably expected to result from implementation of the verification program, and

(iii) the labor and nonlabor costs of administration of the verification system, the degree to which the Immigration and Naturalization Service is capable of providing timely and accurate information to the administering entity in order to permit a reliable determination of immigration status, and such other factors as such Secretary deems relevant.

(D) **DEFINITIONS.**—In this paragraph:

(i) The term "covered program" means each of the following programs:

(I) The aid to families with dependent children program under part A of title IV of the Social Security Act.

(II) Any State program under a plan approved under title I, X, XIV, or XVI of the Social Security Act.

(III) The unemployment compensation program under section 3304 of the Internal Revenue Code of 1954.

(ii) The term "appropriate Secretary" means, with respect to the covered program described in—

(I) subclauses (I) and (II) of clause (i), the Secretary of Health and Human Services; and

(II) clause (i)(III), the Secretary of Labor.

(iii) The term "administering entity" means, with respect to a covered program, the State agency responsible for the administration of the program in a State.

AMENDMENT NO. 3

Page 61, line 17, after "PROGRAM.—" insert "(1)".

Page 78, line 6, after "Government" insert "(but in any event including the program of aid to families with dependent children under part A of title IV of the Social Security Act)".

Page 79, line 1, strike "assistance furnished" and insert "assistance (other than aid to families with dependent children) which is furnished".

Page 80, strike line 1 and insert the following:

"(I) Titles V, XVI, and XX, and parts B, D, and E of title IV, of the Social Security Act (and titles I, X, XIV, and XVI of such Act as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972).

Page 81, line 14, strike "(b) TABLE OF CONTENTS AMENDMENT.—" and insert "(2)".

Page 81, immediately before line 17, insert the following new subsection:

(b) CONFORMING AMENDMENTS.—(1) Section 402 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(f)(1) For temporary disqualification of certain newly legalized aliens from receiving aid to families with dependent children, see subsection (h) of section 245A of the Immigration and Nationality Act.

"(2) In any case where an alien is disqualified from receiving aid under such subsection (h) is the parent of a child who is not so disqualified and who (without any adjustment of status under such section 245A) is considered a dependent child under subsection (a)(33), or is the brother or sister of such a child, subsection (a)(38) shall not apply, and the needs of such alien shall not be taken into account in making the determination under subsection (a)(7) with respect to such child, but the income of such alien (if he or she is the parent of such child) shall be included in making such determination to the same extent that income of a stepparent is included under subsection (a)(31)."

(2)(A) Section 472(a) of such Act is amended by adding at the end thereof (after and below paragraph (4)) the following new sentence:

"In any case where the child is an alien disqualified under section 245(h) of the Immigration and Nationality Act from receiving aid under the State plan approved under section 402 in or for the month in which such agreement was entered into or court proceedings leading to the removal of the child from the home were instituted, such child shall be considered to satisfy the requirements of paragraph (4) (and the corresponding requirements of section 473(a)(1)(B)), with respect to that month, if he or she would have satisfied such requirements but for such disqualification."

(B) Section 473(a)(1) of such Act is amended by adding at the end thereof (after and below subparagraph (C)) the following new sentence:

"The last sentence of section 472(a) shall apply, for purposes of subparagraph (B), in any case where the child is an alien described in that sentence."

AMENDMENT NO. 4

Page 101, line 15, before the period insert the following:
and inserting in lieu thereof "before January 1, 1993,"

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I. PURPOSES AND SCOPE

The purposes of the bill, as stated in the Report of the Committee on the Judiciary (H. Rept. 99-682, Part 1), are to "control illegal immigration to the U.S., make limited changes in the system for legal immigration and provide a controlled legalization program for certain undocumented aliens who have entered this country prior to 1982.

"The bill establishes penalties for employers who knowingly hire undocumented aliens, thereby ending the magnet that lures them to this country. It also revises the procedures for the temporary entry of foreign agricultural workers under the H-2 program and provides permanent residence to certain aliens performing field work with respect to perishable crops." (pp. 45-46)

The bill was sequentially referred to the Committee on Ways and Means for consideration of such portions of the bill and amendments that fall within the Committee's jurisdiction. Only the following portions of the bill are within the jurisdiction of the Committee on Ways and Means: the portion of section 101 that requires the Attorney General to establish a system of verifying the social security number of all individuals seeking employment in the United States; section 121, which requires the development of a system to verify the immigration status of individuals applying for benefits under the Aid to Families with Dependent Children (AFDC) program, the Supplemental Security Income (SSI) program, State unemployment compensation programs and the adult assistance programs in the territories; the portion of section 301 of the bill deleting the expiration date of the exclusion from Federal Unemployment Tax (FUTA) of wages paid to certain alien farmworkers; and the portion of section 201 that restricts the eligibility of certain newly legalized aliens for public assistance provided through programs within the Committee's jurisdiction.

II. SUMMARY OF AMENDMENTS

1. Social Security Number Verification

The Committee agreed to strike the provision in the bill that requires the Attorney General to establish a system to verify the social security numbers of all applicants for employment in the United States. The Committee amendment instead requires the Social Security Administration, in conjunction with the Attorney General and the Department of Labor, to conduct a study of the feasibility, costs and privacy implications of establishing a social security number validation system to help carry out the purposes of the Immigration and Nationality Act.

2. Legalization of Illegal Aliens and Eligibility for Certain Public Assistance Programs

The Committee made clarifying and technical changes to the provision in the bill that disqualifies certain newly legalized aliens from public assistance programs to make clear that the disqualification applies to the Aid to Families with Dependent Children (AFDC) program and not to other public assistance programs within the Committee's jurisdiction.

3. Verification of Immigration Status of Aliens Applying for Public Assistance Benefits

The Committee amended the provision in the bill that requires States and other agencies administering public assistance programs to establish an automated system of verifying the alien status of individuals applying for aid. The Committee amendment allows the respective Secretaries with administrative responsibilities over the programs to waive the requirement that a verification system be established if the Secretary finds that such a program would not be cost effective or that an alternative system is in place which is as timely and effective. In addition, the Supplemental Security Income program (SSI) would not be subject to the verification system requirement.

4. Federal Unemployment Tax (FUTA) on Wages Paid to Nonresident Farmworkers

The Committee amended that provision of the bill that makes permanent the current temporary exclusion from Federal Unemployment Tax (FUTA) of wages paid to certain foreign agricultural workers. The Committee amendment extends the current exclusion for five years, from December 31, 1987, to December 31, 1992.

In addition to the Committee's amendments, the Committee authorized the Chairman or his designee to request of the Committee on Rules that an amendment be made in order under the rule for consideration of H.R. 3810, which would disqualify the special agricultural workers who are granted permanent resident status under the bill from receipt of Aid to Families with Dependent Children (AFDC) in the same manner that the aliens being granted amnesty under the bill are disqualified from such benefits.

III. EXPLANATION OF AMENDMENTS

1. *Social Security Number Verification (sec. 101)*

Present Law.—The social security number is issued by the Social Security Administration as a filing system device, under which reports of workers' earnings can be maintained and benefits later calculated according to each worker's individual record. Citizens may be required by law to give their social security numbers only for a limited number of purposes—taxpayer identification, State drivers' licenses, receipt of certain public benefits. The Social Security Administration is prohibited from disclosing anyone's social security number, or wage data recorded on an individual's earnings record, except for limited governmental disclosure purposes set out in the statute (e.g. the parent locator service under the Child Support Enforcement program).

H.R. 3810.—Section 101 of H.R. 3810 requires the Attorney General to establish a system to verify the social security number of all applicants for employment, temporary or permanent, in the United States. The bill does not define the term "verify", and would apparently allow the use of social security taxpayer information to conduct the verification process, if deemed necessary. The provision further states that nothing in the bill should be construed as establishing a national identity card.

Committee on Ways and Means Amendment.—The amendment strikes the provision in the bill requiring the Attorney General to establish a verification system, and instead requires the Social Security Administration, in conjunction with the Attorney General and the Secretary of Labor, to conduct a study of the feasibility and costs of establishing a social security number validation system to help carry out the purposes of the Immigration and Nationality Act. The study would also analyze the privacy concerns that would be raised by the establishment of such a system. The study would be due in 2 years and be made to the Committee on Ways and Means and the Committee on the Judiciary in the House, and to the Committee on Finance and the Committee on the Judiciary in the Senate.

2. *Verification of Immigration Status of Aliens Applying for Public Assistance Benefits (sec. 121)*

Present Law.—Section 1137 of the Social Security Act requires that States establish an income and eligibility verification system (IEVS) for certain public assistance programs. Section 1137 was established by the Deficit Reduction Act of 1984 and was effective April 1, 1985. Although the Secretaries of the respective Departments may permit States to delay implementation, such delays may not extend beyond September 30, 1986.

Under IEVS, the State agencies administering AFDC, Medicaid, Unemployment Compensation, Food Stamps and the adult assistance programs in the territories (and SSA in the case of SSI) must request and make use of: (1) unearned income information available from the Internal Revenue Service; and (2) quarterly wage information. Independent verification of the unearned income information is required and recipient confidentiality must be protected.

The Aid to Families with Dependent Children (AFDC) program, the Supplemental Security Income (SSI) program and the Unemployment Compensation (UC) program each have policies for verifying the alien status of applicants. These are described below.

AFDC: To be eligible for AFDC, an individual must be a citizen of the United States or an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Applicants must provide documentation of citizenship or immigration status according to procedures established by each State. To document alien status, States require that the applicant furnish various forms of INS documentation or a court order or INS correspondence which describes the individual's status. The quality control system reviews the accuracy of State eligibility decisions and verifies each factor of eligibility, including alien status.

SSI: To be eligible for SSI, an individual must have resided in the United States for 30 consecutive days and be a citizen, a national, or an alien lawfully admitted for permanent residence or permanently residing in the United States under color of law. The statute stipulates that eligibility may not be determined solely on the basis of declarations by the applicant. The HHS Secretary has authority to prescribe the documentation required to establish alien status. Relevant information must be verified from independent sources. To demonstrate alien status, an individual may provide an alien registration receipt card or other proof of lawful admission.

UC: Eligibility for unemployment benefits is determined under State law. In order to qualify for benefits, an unemployed person usually must have worked recently for a specific period of time and earned a specific amount of wages. In general, there are three major factors in determining eligibility: (1) the amount of recent employment and earnings; (2) demonstrated ability and willingness to seek and accept suitable employment; and (3) certain disqualifications related to a claimant's most recent separation from work or job offer refusal.

Federal law, section 3304(a)(14)(A) of the Federal Unemployment Tax Act, provides that unemployment compensation shall not be payable on the basis of services performed by an alien unless such alien is an individual who was lawfully admitted for permanent residence at the time such services were performed, was lawfully present for purposes of performing such services, or was permanently residing in the United States under color of law at the time such services were performed (including an alien who is lawfully present in the United States as a result of the application of the provisions of section 203(a)(7) or section 212(d)(5) of the Immigration and Nationality Act).

In applying for unemployment benefits, individuals are asked if they are citizens of the U.S. or aliens. If they identify themselves as aliens, they are asked to supply documentation of their alien status in order to determine if they are permitted to work in the U.S. Individual States can verify the accuracy of the documentation in whatever manner they see fit.

H.R. 3810.—H.R. 3810 amends section 1137 of the Social Security Act, which requires that States establish an income and eligibility

verification system (IEVS) for certain public assistance programs. It would mandate that States require individuals, as a condition of eligibility for AFDC, Medicaid, Food Stamps, Unemployment Compensation and the adult assistance programs in the territories, to submit a declaration in writing of their citizenship status. If the individual is not a citizen of the U.S., alien registration documentation must be supplied (including the alien admission number) or such other documents as the State determines constitute reasonable evidence of satisfactory immigration status. Such a requirement would also be a condition of eligibility under the SSI program as administered by the Social Security Administration (SSA).

The State (and SSA in the case of SSI) would be required to use this documentation to verify, with the INS, the individual's immigration status through an automated system. If the declaration is supplied but the documentation is not, or the documentation is not verified, a State may not delay, deny, reduce or terminate eligibility until the individual has been given a reasonable period of time to demonstrate alien status.

H.R. 3810 provides for 100 percent Federal reimbursement for the costs of implementation and operation of this new requirement for each of the programs required to participate. The INS would be required to establish its automated verification system by October 1, 1987. States would be required to participate in the system beginning on October 1, 1988.

Committee on Ways and Means Amendment.—The Committee agreed to the mandatory alien verification system as proposed in H.R. 3810 with several modifications. The Secretaries of the respective Departments would be required to report by April 1, 1988 on whether it is cost effective to apply the requirement to the AFDC and Unemployment Compensation programs and the adult assistance programs in the territories. This report would also note whether and the extent to which waivers of the requirement should be granted. The new verification system would not apply to the Federal SSI program.

A Secretary would be permitted to grant a waiver of the application of the system to a program or its application in a State or other geographic area if there is in effect an alternative system that is as effective, accurate and timely or if the requirement is not cost effective. Any alternate system must, at a minimum, include the same hearings and appeals rights as provided in the bill.

To determine cost effectiveness, the Secretary would consider: (1) the number of aliens claiming benefits in comparison to the total seeking benefits; (2) any savings that can be attributed to implementation of the system; (3) labor and non-labor costs of administration; (4) whether the Immigration and Naturalization Service (INS) can provide timely and accurate information that is reliable; and (4) such other factors as the Secretary determines to be appropriate.

The General Accounting Office would also be required to report to Congress on the results of the INS alien verification pilot projects now underway and on implementation of the new verification system.

3. Legalization of Illegal Aliens and Eligibility for Certain Public Assistance Programs (secs. 201 and 204)

Present Law.—The AFDC, SSI and UC programs each have policies for determining the eligibility of lawfully admitted aliens. These are described below.

AFDC: To be eligible for AFDC, an individual must be a citizen of the United States or an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Illegal aliens are ineligible for assistance. To determine eligibility and benefits of legally admitted (non-refugee) aliens, the income and resources of the sponsor are attributed to the alien during the 3 years after entry into the United States. Allowance is made for the needs of the sponsor and his family; the remainder is considered available to support the alien.

SSI: To be eligible for SSI, an individual must have resided in the United States for 30 consecutive days and be a citizen, national, or an alien lawfully admitted for permanent residence or permanently residing in the United States under color of law. In the SSI program, the income and resources of a legally admitted alien's sponsor are considered in determining eligibility and benefits. After taking into account the needs of the sponsor and his family, the remainder of the sponsor's income is deemed to be available to the alien applicant for a 3-year period after entry into the United States. The requirement to consider the sponsor's income does not apply to: (1) aliens who become blind or disabled after entry into the United States; (2) refugees; and (3) persons who have been granted political asylum.

Unemployment Compensation: Eligibility for unemployment benefits is determined under State law. In order to qualify for benefits, an unemployed person usually must have worked recently for a specified period of time and earned a specified amount of wages. In general there are three major factors in determining eligibility: (1) the amount of recent employment and earnings; (2) demonstrated ability and willingness to seek and accept suitable employment; and (3) certain disqualifications related to a claimant's most recent separation from work or job offer refusal.

H.R. 3810.—The bill would establish a procedure for extending legal status to two groups of aliens. The first group (known as the "amnesty" group) consists of certain aliens who entered the United States unlawfully before January 1, 1982 and who have remained in the U.S. in a continuous, and unlawful status since that time. Under the bill, this group would be extended temporary resident status. After one year, this temporary status could be adjusted to that an alien lawfully admitted for permanent residence.

The second group (known as special agricultural workers) is comprised of certain seasonal agricultural workers. In this case, permanent resident status would be extended to aliens who have performed at least 60 man-days of seasonal agricultural services during the 12-month period ending May 1, 1986 and who are admissible as immigrants. This second group of aliens would be treated as permanent residents for all purposes and would be eligible for federal public assistance programs.

During the 5-year period beginning on the date an alien in the amnesty group is granted lawful temporary resident status, the alien would not be eligible for any needs-based program of financial assistance provided under Federal law. The term "program of financial assistance furnished under Federal law" is not defined. Instead, H.R. 3810 specifies that such programs would be identified by the Attorney General after consultation with other department heads.

This prohibition against receiving Federal financial assistance would *not* apply to Cuban-Haitian entrants or to the special agricultural workers. H.R. 3810 appears to deny newly legalized aliens eligibility for AFDC and may also prohibit participation in the Title IV-E foster care program. The bill does not appear to restrict the alien's access to Title IV-B child welfare services or Title XX social services since these are not generally considered to be programs of financial assistance. In addition, it does not appear to restrict eligibility for unemployment compensation because such benefits are provided under State law.

The Attorney General *may* allow Federal assistance to be extended to recently legalized aliens because of age, blindness, disability or medical conditions that require treatment in the interest of public health or because of serious illness or injury. However, according to the House Judiciary Committee report, this is not intended to authorize automatic access to SSI, Medicaid or Medicare by the newly legalized aliens.

H.R. 3810 authorizes a program of Federal financial assistance to reimburse States for the cost of providing State or locally-funded assistance to the newly legalized aliens during the 5-year period beginning on the date the alien is granted temporary resident status. It also permits State and local governments to limit benefits to newly legalized aliens.

Subject to the amounts provided in advance in appropriation Acts, the bill provides for 100 percent reimbursement of these costs. Programs of public assistance eligible for reimbursement are defined as "programs existing in a State or local jurisdiction which . . . provide for cash, medical, or other assistance designed to meet the basic subsistence needs of individuals. . . ."

The authority to appropriate funds for State legalization assistance is effective for FY 1987 and each of the four succeeding fiscal years.

Committee on Ways and Means Amendment.—The Committee amendment clarifies that for purposes of public assistance programs under the jurisdiction of the Committee on Ways and Means, the 5-year disqualification for the amnesty group applies only to the AFDC program and only with regard to the newly legalized aliens. It does not apply to the following programs: child welfare services, child support enforcement, foster care and adoption assistance, SSI, or the social services block grant.

In addition, the Committee amendment would clarify that the disqualification does not apply to U.S. citizen children in families that are otherwise disqualified under this section. The amendment would also prescribe the method for treating the income and needs of the disqualified members when determining the eligibility of the U.S. citizen child.

4. *Federal Unemployment Tax (FUTA) on Wages Paid to Nonresident Farmworkers (sec. 301)*

Present Law.—Under the Immigration and Nationality Act, residents of foreign countries who do not intend to abandon such residency may be admitted to the United States to perform agricultural labor for a temporary period of time. The workers are admitted to the U.S. pursuant to sections 214(c) and 101(a)(15)(H) of the Immigration and Nationality Act. In general, under those sections of the Act, the workers are admitted to the U.S. only after the Department of Labor certifies that there are no domestic workers available to perform the labor. These workers are known as H-2 workers and must return to their native countries upon the completion of their work.

Under section 3306(c)(1)(B) of the Internal Revenue Code, wages paid to nonresident farmworkers admitted to the U.S. under the above Act are not subject to Federal Unemployment Tax (FUTA). This exemption from FUTA tax effectively exempts these wages from State unemployment taxes. The exemption from the FUTA tax expires on December 31, 1987.

H.R. 3810.—Section 301 amends the Internal Revenue Code to make the exclusion from FUTA tax permanent.

Committee on Ways and Means Amendment.—The Committee amendment would extend the current exclusion from the FUTA tax for 5 years, through December 31, 1992.

The H-2 program, which allows foreign workers to come into the U.S. to perform labor when domestic workers cannot be found, will be greatly expanded under this bill. The major concern expressed about the exclusion is that it provides an incentive to seek H-2 workers at the expense of domestic workers.

Under the bill as reported, the President must report to the Congress within two years of the date of enactment on the operation of the expanded H-2 program authorized under the bill. This report would include recommendations on removing the disincentives to hiring domestic workers. By extending the exclusion through 1992, the Committee on Ways and Means will have the opportunity to examine the exclusion in light of the expanded H-2 program and with the benefit of the President's report.

IV. VOTE OF THE COMMITTEE AND OTHER MATTERS TO BE DISCUSSED
UNDER THE RULE OF THE HOUSE

In compliance with the subdivision (B) of clause (2)(1)(2) of Rule XI of the Rules of the House of Representatives, the Committee states that the bill was approved by voice vote.

In compliance with the subdivision (A) of clause (2)(1)(3) of Rule XI, the Committee reports that the amendments are consistent with the oversight findings of the Committee on Ways and Means and the explanations of the amendments contained in the section of this report.

In compliance with the subdivision (D) of clause (2)(1)(3) of Rule XI, the Committee states that no oversight findings or recommendations have been submitted by the Committee on Government Operations with respect to the subject matter contained in the bill.

In compliance with the clause (2)(1)(4) of Rule XI, the Committee estimates that enactment of the bill will have no inflationary impact on the economy.

In compliance with the subdivision (B) of clause (2)(1)(3) of Rule XI, the Committee states that the bill does not increase tax expenditures and that a discussion of budget authority is contained in the report of the Congressional Budget Office.

In compliance with clause 7(a) of Rule XIII, the following statement is made relative to the budget effects of the provisions of H.R. 3810, as reported by the Committee.

With respect to the provisions contained in the bill, the Committee states that it agrees with the estimates of the Congressional Budget Office. These estimates are presented for fiscal years 1986 to 1991 for the unified budget.

In compliance with the subdivision (C) of clause (2)(1)(3) of Rule XI, the Committee states that the Congressional Budget Office has examined H.R. 3810, as reported by the Committee and has submitted the following statements:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 1, 1986.

Hon. DAN ROSTENKOWSKI,
*Chairman, Committee on Ways and Means,
U.S. House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared this cost estimate for amendments to H.R. 3810, the Immigration Control and Legalization Amendments Act of 1986, as ordered reported by the House Committee on Ways and Means on July 30, 1986. H.R. 3810 was ordered reported by the House Committee on the Judiciary on June 25, 1986.

This estimate provides the spending impacts of the Committee on Ways and Means amendments to H.R. 3810. The original CBO estimate for H.R. 3810, as reported by the Committee on the Judiciary, is attached to provide background information. The table below shows the original estimate of H.R. 3810's impact on spending, the Committee on Ways and Means changes to spending, and the resulting estimated spending, revenue, and federal deficit totals for the bill as amended.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

[By fiscal year, in millions of dollars]

	1986	1987	1988	1989	1990	1991
Judiciary bill:						
Required budget authority/estimated authorization level	434	655	1,170	1,885	2,201	2,277
Estimated outlays		480	819	1,779	2,348	2,475
Ways and Means:						
Required budget authority/estimated authorization level		(¹)	-130	-135	-136	-136
Estimated outlays		(¹)	-130	-135	-136	-136
Total spending:						
Required budget authority/estimated authorization level	434	655	1,040	1,750	2,065	2,141
Estimated outlays		480	699	1,644	2,212	2,339

ESTIMATED COST TO THE FEDERAL GOVERNMENT—Continued

(By fiscal year, in millions of dollars)

	1986	1987	1988	1989	1990	1991
Estimated revenues		70	166	54	54	.....
Net budget impact: estimated net increase or decrease (—) in the deficit.....		410	533	1,590	2,158	2,339

¹ Less than \$500,000.

The Committee on Ways and Means reported several amendments to H.R. 3810. The first would strike the requirement for a system to verify the social security account number of all applicants for employment in the United States. The new provision would instead require the Social Security Administration, in conjunction with the Attorney General and the Secretary of Labor, to conduct a study of the feasibility and costs of establishing such a system and report to the Congress in two years. CBO's previous cost estimate for H.R. 3810 estimated the cost for social security account number verification to be approximately \$130 million annually, beginning in fiscal year 1988. These costs would be avoided by this amendment, although there would be some costs for the required study. Due to uncertainty about the scope of such a study, CBO cannot estimate these costs.

The System for Alien Verification of Eligibility (SAVE), which would require a number of federal benefit programs to check with the Immigration and Naturalization Service as to the resident status of aliens applying for program benefits, was also amended. The amendments would permit a program or jurisdiction not to use SAVE if waivers were granted by Department Secretaries. Waivers could be given if alternative verification systems were found to be as effective or if the administrative costs of SAVE exceeded any estimated savings. Without knowing more about SAVE and the extent to which waivers might be granted, the CBO estimate assumed that savings and costs would be approximately offsetting. If the cost effectiveness of SAVE could be measured accurately and waivers granted accordingly, however, these amendments would be likely to result in federal budgetary savings.

In addition, the requirement to use SAVE to verify the status of persons applying for Supplemental Security Income (SSI) benefits was removed. CBO's estimate of H.R. 3810 included estimated net costs of \$5 million in 1989 and \$6 million in 1990 and 1991 for the use of SAVE in SSI. These costs would be avoided by the amendment.

The provision of H.R. 3810 that would permanently exempt employers from paying Federal Unemployment Tax Act taxes on wages paid to H-2 agricultural workers was amended to expire on January 1, 1993.

Finally, the Committee added a number of programs to the list of those that legalized aliens would not be precluded from receiving for five years. CBO estimates that this amendment would not have a significant budgetary effect.

If you wish further details on this estimate, please call me or have your staff contact Janice Peskin.

CHAPTER 5—DEPORTATION; ADJUSTMENT OF STATUS

* * * * *

ADJUSTMENT OF STATUS OF CERTAIN ENTRANTS BEFORE JANUARY 1, 1982, TO THAT OF PERSON ADMITTED FOR LAWFUL RESIDENCE

SEC. 245A. (a) * * *

* * * * *

(h) TEMPORARY DISQUALIFICATION OF NEWLY LEGALIZED ALIENS FROM RECEIVING CERTAIN PUBLIC WELFARE ASSISTANCE.—

(1) *IN GENERAL.*—During the five-year period beginning on the date an alien was granted lawful temporary resident status under subsection (a), and notwithstanding any other provision of law—

(A) except as provided in paragraph (2), the alien is not eligible for—

(i) any program of financial assistance furnished under Federal law (whether through grant, loan, guarantee, or otherwise) on the basis of financial need, as such programs are identified by the Attorney General in consultation with other appropriate heads of the various departments and agencies of Government (but in any event including the program of aid to families with dependent children under part A of title IV of the Social Security Act),

(ii) medical assistance under a State plan approved under title XIX of the Social Security Act, and

(iii) assistance under the Food Stamp Act of 1977; and

(B) a State or political subdivision therein may, to the extent consistent with subparagraph (A), provide that the alien is not eligible for the programs of financial assistance or for medical assistance described in subparagraph (A)(ii) furnished under the law of that State or political subdivision.

(2) *EXCEPTIONS.*—Paragraph (1) shall not apply—

(A) to a Cuban and Haitian entrant (as defined in paragraph (1) or (2)(A) of section 501(e) of Public Law 96-422, as in effect on April 1, 1983),

(B) in the case of assistance (other than aid to families with dependent children) which is furnished to an alien who is an aged, blind, or disabled individual (as defined in section 1614(a)(1) of the Social Security Act), or

(C) in the case of medical assistance (i) for care and services provided to an alien who is under 18 years of age, (ii) for emergency services (as defined for purposes of section 1916(a)(2)(D) of the Social Security Act) or (iii) for services described in section 1916(a)(2)(B) of such Act (relating to services for pregnant women).

(3) *TREATMENT OF CERTAIN PROGRAMS.*—Assistance furnished under any of the following provisions of law shall not be construed to be financial assistance described in paragraph (1)(A)(i):

- (A) *The National School Lunch Act.*
- (B) *The Child Nutrition Act of 1966.*
- (C) *The Vocational Education Act of 1963.*
- (D) *Chapter 1 of the Education Consolidation and Improvement Act of 1981.*
- (E) *The Headstart-Follow Through Act.*
- (F) *The Job Training Partnership Act.*
- (G) *Subparts 4 and 5 of part A of title IV of the Higher Education Act of 1965.*
- (H) *The Public Health Service Act.*
- (I) *Title V of the Social Security Act.*
- (I) **Titles V, XVI, and XX, and parts B, D, and E of title IV, of the Social Security Act (and titles I, X, XIV, and XVI of such Act as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972).**

* * * * *

CHAPTER 8—GENERAL PENALTY PROVISIONS

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UNLAWFUL EMPLOYMENT OF ALIENS

SEC. 274A. (a) * * *

(b) **EMPLOYMENT VERIFICATION SYSTEM.**—*The requirements referred to in paragraphs (1)(B) and (3) of subsection (a) are, in the case of a person or other entity hiring, recruiting, or referring an individual for employment in the United States, the requirements specified in the following three paragraphs (and, to the extent applicable, paragraph (7)(C)):*

(1) **ATTESTATION AFTER EXAMINATION OF DOCUMENTATION AND VALIDATION OF SOCIAL SECURITY ACCOUNT NUMBER.**

(A) **IN GENERAL.**—*The person or entity must attest, under penalty of perjury and on a form established or designated by the Attorney General by regulation, that he has verified that the individual is eligible to be employed (or recruited or referred for employment) in the United States—*

(i) by examining—

(I) the individual's United States passport, or the individual's unexpired foreign passport, if the foreign passport has an appropriate, unexpired endorsement of the Attorney General authorizing the individual's employment in the United States; or

(II) a document described in subparagraph (B) and a document described in subparagraph (C); and

(ii) by validating (to the extent and in the manner required under paragraph (7)(C)) the social security account number presented by the individual.

in the United States by examining—

(i) the individual's United States passport, or the individual's unexpired foreign passport if the foreign passport has an appropriate, unexpired endorsement

of the Attorney General authorizing the individual's employment in the United States, or

(ii) a document described in subparagraph (B) and a document described in subparagraph (C).

A person or entity has complied with the requirement of clause (i) of this subparagraph the preceding sentence with respect to examination of a document if the document reasonably appears on its face to be genuine. If an individual provides a document or combination of documents that reasonably appears on its face to be genuine and that is sufficient to meet the requirements of clause (i), such sentence, nothing in this paragraph shall be construed as requiring the person or entity to solicit the production of any other document or as requiring the individual to produce such a document.

* * * * *

(7) **SOCIAL SECURITY ACCOUNT NUMBER VALIDATION SYSTEM.**—

(A) **ESTABLISHMENT OF SYSTEM.**—*The Attorney General, in cooperation with the Secretaries of Labor and Health and Human Services, shall establish a method to validate the social security account numbers of individuals applying to be hired, or recruited or referred for a fee, for employment in the United States.*

(B) **PUBLICATION.**—*The Attorney General shall provide for publication in the Federal Register of notice of the establishment of the validation method and the procedures for its use not earlier than 6 months, and not later than 18 months, after the date of the enactment of this section.*

(C) **IMPLEMENTATION.**—*Beginning on an effective date (not earlier than 90 days, and not later than 180 days, after the date final regulations are published under subparagraph (B)) set forth by the Attorney General, in order to comply with the requirement of paragraph (1)(A) of this subsection in the case of a person or other entity hiring, or recruiting or referring for a fee, an individual for employment in the United States, the person or other entity must, pursuant to the verification method—*

(i) submit the social security account number of the individual; and

(ii) be provided and record on the form designated or established for purposes of that paragraph a validation code indicating that the number submitted is valid.

* * * * *

SOCIAL SECURITY ACT

* * * * *

TITLE IV—GRANTS TO STATES FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN AND FOR CHILD-WELFARE SERVICES¹

* * * * *

PART A—AID TO FAMILIES WITH DEPENDENT CHILDREN

* * * * *

STATE PLANS FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN

SEC. 402. (a) * * *

* * * * *

(f)(1) For temporary disqualification of certain newly legalized aliens from receiving aid to families with dependent children, see subsection (h) of section 245A of the Immigration and Nationality Act.

(2) In any case where an alien disqualified from receiving aid under such subsection (h) is the parent of a child who is not so disqualified and who (without any adjustment of status under such section 245A) is considered a dependent child under subsection (a)(33), or is the brother or sister of such a child, subsection (a)(38) shall not apply, and the needs of such alien shall not be taken into account in making the determination under subsection (a)(7) with respect to such child, but the income of such alien (if he or she is the parent of such child) shall be included in making such determination to the same extent that income of a stepparent is included under subsection (a)(31).

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PART E—FEDERAL PAYMENTS FOR FOSTER CARE AND ADOPTION ASSISTANCE

* * * * *

FOSTER CARE MAINTENANCE PAYMENTS PROGRAM

SEC. 472. (a) * * *

* * * * *

In any case where the child is an alien disqualified under section 245A(h) of the Immigration and Nationality Act from receiving aid under the State plan approved under section 402 in or for the month in which such agreement was entered into or court proceedings leading to the removal of the child from the home were instituted, such child shall be considered to satisfy the requirements of paragraph (4) (and the corresponding requirements of section 473(a)(1)(B)), with respect to that month, if he or she would have satisfied such requirements but for such disqualification.

* * * * *

ADOPTION ASSISTANCE PROGRAM

SEC. 473. (a)(1) * * *

The last sentence of section 472(a) shall apply, for purposes of subparagraph (B), in any case where the child is an alien described in that sentence.

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TITLE XVI—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

* * * * *

PART B—PROCEDURAL AND GENERAL PROVISIONS

PAYMENTS AND PROCEDURES

Payment of Benefits

SEC. 1631. (a) * * *

* * * * *

Applications and Furnishing of Information

(e)(1)(A) The Secretary shall, subject to subparagraph (B), prescribe such requirements with respect to the filing of applications, the suspension or termination of assistance, the furnishing of other data and material, and the reporting of events and changes in circumstances, as may be necessary for the effective and efficient administration of this title.

(B) The requirements prescribed by the Secretary pursuant to subparagraph (A) shall require that eligibility for benefits under this title will not be determined solely on the basis of declarations by the applicant concerning eligibility factors or other relevant facts, and that relevant information will be verified from independent or collateral sources and additional information obtained as necessary in order to assure that such benefits are only provided to eligible individuals (or eligible spouses) and that the amounts of such benefits are correct. For this purpose and for purposes of federally administered supplementary payments of the type described in section 1616(a) of this Act (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93-66), the Secretary shall, as may be necessary, request and utilize information available pursuant to section 6103(1)(7) of the Internal Revenue Code of 1954, and any information which may be available from State systems under section 1137 of this Act, and shall comply with the requirements applicable to States (with respect to information available pursuant to section 6103(1)(7)(B) of such code) under subsections (a)(6) ~~and (e), (e), and (d)~~ of such section 1137.

* * * * *

Internal Revenue Code of 1954

* * * * *

EMPLOYMENT TAX—EMPLOYEES

Subtitle C—Employment Taxes and Collection of Income Tax at Source

* * * * *

CHAPTER 23—FEDERAL UNEMPLOYMENT TAX ACT

- Sec. 3301. Rate of tax.
 Sec. 3302. Credits against tax.
 Sec. 3303. Conditions of additional credit allowance.
 Sec. 3304. Approval of State laws.
 Sec. 3305. Applicability of State law.
 Sec. 3306. Definitions.
 Sec. 3307. Deductions as constructive payments.

SEC. 3231(i) * * *

* * * * *

SEC. 3306. DEFINITIONS. * * *

* * * * *

(c) **EMPLOYMENT**—For purposes of this chapter, the term “employment” means any service performed prior to 1955, which was employment for purposes of subchapter C of chapter 9 of the Internal Revenue Code of 1939 under the law applicable to the period in which such service was performed, and (A) any service, of whatever nature, performed after 1954 by an employee for the person employing him, irrespective of the citizenship or residence of either, (i) within the United States, or (ii) on or in connection with an American vessel or American aircraft under a contract of service which is entered into within the United States or during the performance of which and while the employee is employed on the vessel or aircraft it touches at a port in the United States, if the employee is employed on and in connection with such vessel or aircraft when outside the United States, and (B) any service, of whatever nature, performed after 1971 outside the United States (except in a contiguous country with which the United States has an agreement relating to unemployment compensation) by a citizen of the United States as an employee of an American employer (as defined in subsection (j)(3)), except—

- (1) agricultural labor (as defined in subsection (k)) unless—
 (A) such labor is performed for a person who—

(i) during any calendar quarter in the calendar year or the preceding calendar year paid remuneration in cash of \$20,000 or more to individuals employed in agricultural labor (including labor performed by an alien referred to in subparagraph (B)), or

(ii) on each of some 20 days during the calendar year or the preceding calendar year, each day being in a different calendar week, employed in agricultural labor (including labor performed by an alien referred to in subparagraph (B)) for some portion of the day (whether or not at the same moment of time) 10 or more individuals; and

(B) such labor is not agricultural labor performed **【before January 1, 1988,】** before January 1, 1993, by an individual who is an alien admitted to the United States to perform agricultural labor pursuant to sections 214(c) and 101(a)(15)(II) of the Immigration and Nationality Act;

* * * * *

V. DISSENTING VIEWS ON H.R. 3810 OF HON. JOHN J. DUNCAN, HON. BILL ARCHER, HON. GUY VANDER JAGT, HON. PHILIP M. CRANE, HON. BILL FRENZEL, HON. RICHARD T. SCHULZE, HON. BILL GRADISON, HON. CARROLL A. CAMPBELL, HON. WILLIAM M. THOMAS, HON. RAYMOND J. McGRATH, HON. HAL DAUB, AND HON. JUDD GREGG

The action taken by this Committee on H.R. 3810 leaves a lot to be desired. We take particular exception to allowing preferential treatment, with regard to eligibility for public assistance benefits, to a special category of aliens: Special Agricultural Workers (SAWS).

The general rule established in H.R. 3810 is that aliens granted amnesty and temporary legal resident status are disqualified for five years from AFDC eligibility. However, no comparable disqualification applies to SAWS. Far from it! SAWS may acquire this preferential treatment by showing that they had performed 60 man-days of seasonal agricultural services within the 12 months ending May 1, 1986. A man-day is not defined in H.R. 3810. Under federal law a man-day is defined as working one hour. Therefore, any SAW who works 60 hours a year technically could qualify for a wide range of benefits. This discriminatory effect poses a real problem for Members concerned about equity and fairness in such legislation.

There are at least two other questions which the Committee should have explored more carefully and should have been more assertive about in the amending process. The first concerns which public assistance programs should be subject to a five-year disqualification. The Committee would make AFDC subject to disqualification, but not SSI, Foster Care and Adoption Assistance, Child Welfare Services, Child Support Enforcement and/or Title XX Social Services. There should have been more discussion of, and attention paid, to whether some or all of these other public assistance programs should be given the same treatment as AFDC. It is true, of course, that AFDC is where the big money lies, but that has little or nothing to do with equity and fairness.

A second question concerns the Committee's acquiescence in allowing SAWS to be eligible for public assistance benefits with *no* disqualification period. At a minimum, SAWS should observe the same five-year period of disqualification as applies to other aliens granted temporary resident status in H.R. 3810.

It could appear that Ways and Means cowered before the claim of the other Committee that H.R. 3810 was such a fragile compromise that we should not apply any independent judgement to the provisions which are clearly and undeniably invasions of our jurisdiction. We hope that, at some point in the consideration of H.R. 3810, the Congress will be able to fully and freely consider H.R. 3810 without being bound by some deal made by a few Members of

one Committee which lacked jurisdiction over the subject matter in the first place.

JOHN J. DUNCAN.
BILL ARCHER.
GUY VANDER JAGT.
PHIL CRANE.
BILL FRENZEL.
DICK SCHULZE.
BILL GRADISON.
CARROLL CAMPBELL.
BILL THOMAS.
RAY MCGRATH.
HAL DAUB.
JUDD GREGG.



IMMIGRATION CONTROL AND LEGALIZATION AMENDMENTS ACT OF 1986

AUGUST 5, 1986.—Ordered to be printed

Mr. DINGELL, from the Committee on Energy and Commerce,
submitted the following

REPORT

[To accompany H.R. 3810]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce to whom was referred the bill (H.R. 3810) to amend the immigration and Nationality Act to revise and reform the immigration laws, and for other purposes, having considered the same, report those provisions of the bill within the jurisdiction of the Committee with amendments and recommend that the provisions as amended be agreed to.

The amendments (stated in terms of page and line numbers of the bill as reported by the Committee on the Judiciary) are as follows:

AMENDMENT NO. 1

Page 61, after line 14, insert the following new subsection:

(d) GAO REPORTS.—

(1) REPORT ON CURRENT PILOT PROJECTS.—The Comptroller General shall—

(A) examine current pilot projects relating to the System for Alien Verification of Eligibility (SAVE) operated by, or through cooperative agreements with, the Immigration and Naturalization Service, and

(B) report, not later than October 1, 1987, to Congress and to the Commissioner of the Immigration and Naturalization Service concerning the effectiveness of such projects and any problems with the implementation of such projects, particu-

larly as they may apply to implementation of the system referred to in subsection (c)(1).

(2) **REPORT ON IMPLEMENTATION OF VERIFICATION SYSTEM**—The Comptroller General shall—

(A) monitor and analyze the implementation of such system,

(B) report to Congress and to the appropriate Secretaries described in subsection (c)(4)(D)(ii), by not later than April 1, 1989, on such implementation, and

(C) include in such report such recommendations for changes in the system as may be appropriate.

Page 61, line 7, strike “The amendments” and insert “Except as provided in paragraph (4), the amendments”.

Page 61, after line 10, insert the following new paragraph (and redesignate the succeeding paragraph accordingly):

(4) **USE OF VERIFICATION SYSTEM NOT REQUIRED FOR A PROGRAM IN CERTAIN CASES.**—

(A) **REPORT TO RESPECTIVE CONGRESSIONAL COMMITTEES.**—With respect to each covered program (as defined in subparagraph (D)(i)), each appropriate Secretary shall examine and report to the appropriate Committee of the House of Representatives and of the Senate, by not later than April 1, 1988, concerning whether (and the extent to which)—

(i) the application of the amendments made by subsection (a) to the program is cost-effective and otherwise appropriate, and

(ii) there should be a waiver of the application of such amendments under subparagraph (B).

The amendments made by subsection (a) shall not apply with respect to a covered program until 6 months after the date of receipt of such report with respect to the program.

(B) **WAIVER IN CERTAIN CASES.**—If, with respect to a covered program, the appropriate Secretary determines, on the Secretary’s own initiative or upon an application by an administration entity and based on such information as the Secretary deems persuasive (which may include the results of the report required under subsection (d)(1) and information contained in such an application), that—

(i) the appropriate Secretary or the administering entity has in effect an alternative system of immigration status verification which—

(I) is as effective and timely as the system otherwise required under the

amendments made by subsection (a) with respect to the program, and

(II) provides for at least the hearing and appeals rights for beneficiaries that would be provided under the amendments made by subsection (a), or

(ii) the costs of administration of the system otherwise required under such amendments exceed the estimated savings,

such Secretary may waive the application of such amendments to the covered program to the extent (by State or other geographic area or otherwise) that such determinations apply.

(C) **BASIC FOR DETERMINATION.**—A determination under subparagraph (B)(ii) shall be based upon the appropriate Secretary's estimate of—

(i) the number of aliens claiming benefits under the covered program in relation to the total number of claimants seeking benefits under the program,

(ii) any savings in benefit expenditures reasonably expected to result from implementation of the verification program, and

(iii) the labor and nonlabor costs of administration of the verification system,

the degrees to which the Immigration and Naturalization Service is capable of providing timely and accurate information to the administering entity in order to permit a reliable determination of immigration status, and such other factors as such Secretary deems relevant.

(D) **DEFINITIONS.**—In this paragraph:

(i) The term “covered program” means each of the following programs:

(I) The aid to families with dependent children program under part A of title IV of the Social Security Act.

(II) The medicaid program under title XIX of the Social Security Act.

(III) The supplemental security income program under title XVI of the Social Security Act.

(IV) Any State program under a plan approved under title I, X, XIV, or XVI of the Social Security Act.

(V) The unemployment compensation program under section 3304 of the Internal Revenue Code of 1954.

(IV) The food stamp program under the Food Stamp Act of 1977.

(VII) The programs of financial assistance for housing subject to section 214 of the Housing and Community Development Act of 1980.

(VIII) The program of grants, loans, and work assistance under title IV of the Higher Education Act of 1965.

(ii) The term "appropriate Secretary" means, with respect to the covered program described in—

(I) subclauses (I) through (IV) of clause (i), the Secretary of Health and Human Services;

(II) clause (i)(V), the Secretary of Labor;

(III) clause (i)(VI), the Secretary of Agriculture;

(IV) clause (i)(VII), the Secretary of Housing and Urban Development; and

(V) clause (i)(VIII), the Secretary of Education.

(iii) The term "administering entity" means, with respect to the covered program described in—

(I) subclause (I), (II), (IV), (V), or (VI) of clause (i), the State agency responsible for the administration of the program in a State;

(II) clause (i)(III), the Secretary of Health and Human Services;

(III) clause (i)(VII), the Secretary of Housing and Urban Development, a public housing agency, or another entity that determines the eligibility of an individual for financial assistance; and

(IV) clause (i)(VIII), an institution of higher education involved.

AMENDMENT NO. 2

Page 74, line 6, strike out "to meet" and all that follows through line 9 and insert in lieu thereof the following: "to undergo such a medical examination (including a determination of immunization status) as is appropriate and conforms to generally accepted professional standards of medical practice."

AMENDMENT NO. 3

Page 77, line 22, strike out "paragraph (2)" and insert in lieu thereof "paragraphs (2) and (3)".

Page 78, line 14, insert "and paragraphs (2) and (3)" after "(A)".

Page 78, line 19, strike out "EXCEPTIONS" and insert in lieu thereof "EXCEPTIONS FOR CERTAIN INDIVIDUALS".

Page 78, line 24, insert "or" after the comma.

Page 79, line 4, insert ", or" and insert in lieu thereof a period.

Page 79, strike out lines 5 through 11 and insert in lieu thereof the following:

"(3) RESTRICTED MEDICAID BENEFITS.—

“(A) CLARIFICATION OF ENTITLEMENT.—Subject to the restrictions under subparagraph (B), for the purpose of providing aliens with eligibility to receive medical assistance—

“(i) paragraph (1) shall not apply,

“(ii) aliens who would be eligible for medical assistance but for the provisions of paragraph (1) shall be deemed, for purposes of title XIX of the Social Security Act, to be so eligible, and

“(iii) aliens lawfully admitted for temporary residence under this section, such status not having changed, shall be considered to be permanently residing in the United States under color of law.

“(B) RESTRICTION OF BENEFITS.—

“(i) **LIMITATION TO EMERGENCY SERVICES AND SERVICES FOR PREGNANT WOMEN.**—Notwithstanding any provision of title XIX of the Social Security Act (including subparagraphs (B) and (C) of section 1902(a)(10) of such Act), aliens who, but for subparagraph (A), would be ineligible for medical assistance under paragraph (1), are only eligible for such assistance with respect to—

“(I) emergency services (as defined for purposes of section 1916(a)(2)(D) of the Social Security Act), and

“(II) services described in section 1916(a)(2)(B) of such Act (relating to service for pregnant women).

“(ii) **NO RESTRICTION, FOR EXEMPT ALIENS AND CHILDREN.**—The restrictions of clause (i) shall not apply to aliens who are described in paragraph (2) or who are under 18 years of age.

“(C) DEFINITION OF MEDICAL ASSISTANCE.—In this paragraph, the term ‘medical assistance’ refers to medical assistance under a State plan approved under title XIX of the Social Security Act.

Page 79, line 12, strike out “(3)” and insert in lieu thereof “(4)”.

Page 80, line 2, strike out “(4)” and insert in lieu thereof “(5)”.

Page 80, strike out lines 8 through 16.

AMENDMENT NO. 4

Page 85, line 18, strike out “(2)(C)).” and insert in lieu thereof “(2)(D)) and for 100 percent of the costs of programs of public health assistance (as defined in paragraph (2)(C)) provided to any alien who is, or is applying on a timely basis to the Attorney General to become, an eligible legalized alien. No such reimbursement shall be available to any such program of public health assistance to the extent that the costs of services provided to such eligible legalized aliens have been financed through Federal funds.”.

Page 86, beginning on line 3, strike out "or required in the interest of public health".

Page 86, after line 8, insert the following new subparagraph:

(C) The term "program of public health assistance" means programs in a State or local jurisdiction which—

(i) provide public health services, including immunizations for immunizable diseases, testing and treatment for tuberculosis and sexually-transmitted diseases, and family planning services,

(ii) are generally available to needy individuals residing in the State or locality, and

(iii) receive funding from units of State or local government.

Page 86, line 9, strike out "(C)" and insert in lieu thereof "(D)".

Page 86, line 21, strike out "(b)(2)(C)" and insert in lieu thereof "(b)(2)(D)".

PURPOSE AND SUMMARY

As reported by the Judiciary Committee on July 16, 1986, H.R. 3810 has three major purposes: (1) the control of illegal immigration through employer sanctions and verification of alien status under public assistance programs; (2) the legalization of undocumented aliens residing in the U.S.; and (3) the reform of existing law regarding legal immigration, including the status of special agricultural workers.

The amendments recommended by the Committee on Energy and Commerce apply only to those provisions of Titles I and II of the bill which relate to Medicaid and to Public Health Service Act programs. The Committee makes no recommendations on the bill as a whole or on any portions of the bill not within its jurisdiction.

BACKGROUND AND NEED FOR THE LEGISLATION

An extensive description of the background and history of the legislation appears in House Report 99-682, part 1, and the Committee sees no need to recapitulate. However, the Committee does wish to set forth the major public health and medical care issues relating to aliens who are not lawfully in the country.

The public health and medical needs of undocumented aliens have long been of concern to the Committee. Many of those who have entered this country illegally come from countries in which public health services such as immunization are not routinely available and in which infectious illnesses may be endemic. The poor generally suffer from higher rates of infectious disease than the nonpoor, and poor aliens are no different in this respect. To the extent that they have not been properly immunized, poor aliens, and particularly poor alien children, are vulnerable to the spread of contagious disease. It is a basic public health principle that, as the number of individuals infected with a communicable disease increases, the number of potentially infectious contacts with the larger community increases.

The Committee observes that there are contagious diseases, such as tuberculosis and venereal diseases, against which it is not possible to immunize. The Committee is informed that these diseases may be more prevalent among poor alien populations than among poor Americans. For these diseases, especially those such as tuberculosis that may be asymptomatic, access to primary care (i.e., basic diagnostic and treatment services provided by physicians and other health professionals on an outpatient basis) is essential if the risk of contagion for the larger community is to be effectively contained. With proper primary care, these diseases can be treated during their early stages, and the risk of contagion eliminated. Thus, two elements are essential to any strategy to control contagious disease: the knowledge of, and access to, immunizations, and access to primary care screenings and treatment.

Although poor undocumented aliens may be particularly vulnerable to communicable diseases, they may not, as a practical matter, have access to needed public health or medical services. Living illegally in this country with the fear of being detained or deported, many undocumented aliens are unwilling to consult public clinics, and are unable, due to their inability to pay, to consult private physicians. They tend to work at low-paying agricultural or service sector jobs which rarely offer group health insurance coverage. Since many of them are not considered to be residing in the U.S. "under color of law," they are often ineligible for Medicaid and other publicly-financed health programs, even though many of them contribute to Federal, State, and local tax revenues. The fear of being apprehended, combined with the lack of health coverage and the inability to pay, combine effectively to deny poor undocumented aliens access to needed immunization services and primary care. Not only does this circumstance jeopardize the health status of these individuals and their children, it undermines public health efforts to control contagious diseases.

It is evident to the Committee that the control of contagious disease is of importance not just to the undocumented alien population, but to the community at large. Infections do not recognize borders and do not discriminate on the basis of national origin. In the view of the Committee, there is a strong national public health interest in improving the accessibility of needed immunization and primary care services to this population, and particularly to those on whom the Congress chooses to confer legalized immigration status.

The Committee amendments relate to four discrete issues: verification of immigration status of applicants for Medicaid; medical exams for those seeking legalization; eligibility of otherwise qualified legalized aliens for Medicaid; and reimbursement for the costs of State and local public health services.

VERIFICATION OF IMMIGRATION STATUS OF ALIENS APPLYING FOR MEDICAID

As reported by the Judiciary Committee, the bill would require all States, effective October 1, 1988, to operate an immigration status verification system approved by the Secretary of Health and Human Services. Under this system, States would have to verify

whether every applicant for Medicaid or any other public assistance program is either a citizen or in a "satisfactory" immigration status—i.e., one that does not make the individual ineligible for program benefits. The other public assistance programs to which the same requirement would apply include Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI), as well as unemployment compensation, food stamps, housing assistance, and higher educational assistance programs.

Under the Judiciary Committee's proposal, every individual applying for Medicaid would, as a condition of eligibility, have to file a written declaration, under penalty of perjury, regarding his or her citizen or alien status. An alien would have to present to the State agency an alien registration document or other reasonable evidence of satisfactory immigration status. The State would then have to verify this information with the immigration and naturalization Service (INS), using an automated data system that the INS is required to have operational by October 1, 1987. Pending verification, States would be prohibited from delaying, denying, or terminating benefits to any otherwise qualified individual on the basis of immigration status. Persons whom the State determines do not have a "satisfactory" immigration status would be terminated from Medicaid. States would be entitled to reimbursement for 100 percent of the costs of implementation and operation of their verification systems and would not be liable for Medicaid funds improperly spent due to the failure or delay on the part of the INS to conduct a requested verification.

According to the Judiciary Committee, this provision "had its genesis" in the Systematic Alien Verification for Entitlements project, commonly referred to as "SAVE." Over the past two years, the INS has implemented SAVE pilot projects in a number of States, including Florida, Illinois, and Colorado. According to the National Governors' Association, however, the experience with SAVE to date indicates that the INS data are "incomplete and often inaccurate," and that the capacity of verification to generate savings for the Federal and State government is "questionable." The Governors cite the example of the SAVE pilot project in Colorado, which verifies eligibility for both unemployment compensation and income security programs, including AFDC. Of a total of 147,000 alien applicants in FY 1985, only 17 were found ineligible; savings were only \$3,046, compared with administrative costs, exclusive of staff time, of \$10,500. The Governors also point out that, although this verification mandate would apply in all States, the undocumented alien population is concentrated in only a few. According to a Census Department estimate of the distribution of this population in 1980, over 80 percent were residing in 5 States: California (an estimated 50%); New York (11%); Texas (9%); Illinois (7%), and Florida (4%). The Committee is concerned that, even if mandatory verification in the States with relatively high percentages of undocumented aliens can be shown to be cost-effective, the imposition of this requirement in other States may well waste scarce Federal resources.

The Committee notes that the Administration has urged that the Secretary of HHS be given the authority to waive this verification requirement where implementation would not be cost-effective or

where the State has an alternative approach. The Committee further notes that just over half of all Medicaid eligibles are receiving cash assistance under the AFDC or SSI programs; even if it proves cost-effective to verify eligibility under the AFDC and SSI programs, it would be a useless exercise to subject every cash assistance recipient to yet another verification for purposes of Medicaid eligibility. Given the uneven experience in the SAVE pilot projects to date, given the concerns of both the Governors and the Administration regarding mandatory implementation of such a system in every State for every applicant for every public assistance program, and given the linkage of Medicaid and cash assistance eligibility, the Committee has determined that further study of this issue is required, and that the Secretary of HHS should be given the discretion to waive this requirement wherever appropriate.

Accordingly, the Committee amendment requires the Secretary of HHS to waive the requirement that a State implement a verification system with respect to Medicaid (and other covered public assistance programs) in either of two circumstances: (1) the costs of administration of an alternative system of immigration status verification are likely to exceed the estimated savings; or (2) the State has in effect an alternative system of immigration status verification which is as effective and timely as the mandated system and provides for at least the same protections for beneficiaries, including hearings and appeals rights. The Secretary may waive the verification requirement on either ground with respect to the Medicaid program in any State, or in any portion of any State. Thus, if the Secretary determines that the implementation of such a system for Medicaid eligibility would be cost-effective in one community due to the high concentration of undocumented aliens, he may waive the implementation of the system in the Medicaid program for the rest of the State.

In determining whether the verification requirement should be waived due to lack of cost-effectiveness, the Secretary must estimate (1) the number of aliens claiming Medicaid benefits in relation to the total number of applicants; (2) any savings in Medicaid benefits expenditures reasonably expected to result from a verification program; and (3) the labor and non-labor costs of administering the system in the context of the Medicaid program. The Secretary must also consider the degree to which the INS is capable of providing timely and accurate information to each of the State Medicaid agencies in order to permit a reliable determination of immigration status. It is of particular concern to the Committee that any verification system implemented in any State with respect to its Medicaid program avoid any erroneous denials of coverage to otherwise qualified aliens, including those who fall into any of the judicially or administratively-recognized categories of aliens who are permanently residing in the U.S. under color of law. Finally, the Secretary must also consider other factors relevant to the Medicaid program in determining whether verification would be cost effective. These would include not only the prospect of duplicate verification due to the linkage between Medicaid and AFDC and SSI eligibility, but also the limited possibility that the Medicaid eligibles, including many nursing home residents, who are not receiving cash assistance are likely to be undocumented aliens. The Commit-

tee stresses that the Secretary's determination as to cost-effectiveness for the Medicaid program should be specific to that program, and should not be extrapolated from judgments about the AFDC, SSI or other public assistance programs.

The Committee bill requires that the Secretary of HHS report to this Committee and to the Senate Committee on Finance as to whether the implementation of a mandatory verification system with respect to Medicaid eligibility is cost-effective and otherwise appropriate, and whether (and to what extent) the implementation of this system should be waived in any State or part of a State. The Committee expects that, as part of this report, the Secretary will make—and explain—a separate determination of cost-effectiveness and appropriateness with respect to each State's Medicaid program. The Secretary's report is due no later than April 1, 1988; the scheduled implementation date for the mandatory verification system is October 1, 1988. The Committee believes that the Congress needs 6 months to review the Secretary's report and, if necessary, to develop remedial legislation. The Committee bill therefore provides that implementation of the mandatory system with respect to the Medicaid program cannot occur until 6 months after the submission of the Secretary's report concerning Medicaid.

The Committee bill further provides that the GAO report to the Congress by October 1, 1987, on the SAVE pilot projects and by April 1, 1989, on the implementation of the mandatory verification system. The Committee expects that the Secretary will consider the GAO findings specific to Medicaid in making his determinations with respect to cost-effectiveness, appropriateness, and waivers of the verification system requirements in the case of Medicaid.

MEDICAL EXAMINATIONS

In order to qualify for temporary or permanent legal resident status under the legalization program established by section 201 of the bill, an alien must undergo a medical examination at his or her own expense. The purpose of the examination is to detect physical or medical conditions that may be the basis for exclusion under the Immigration and Nationality Act, including mental retardation, mental illness, chronic alcoholism, drug addiction, and dangerous contagious diseases.

This medical exam offers an ideal opportunity, at no cost to the Federal government, to achieve some basic public health objectives, including control of contagious disease. The Committee is informed that low-income alien populations are less likely to have been properly immunized in their country of origin than comparable U.S. populations, and that they may suffer from higher rates of diseases or conditions which require early detection and treatment to avoid the risk of contagion to the large community. This medical exam can function to identify excludable medical conditions; to determine the individual's immunization status; to educate the patient on the need for immunizations; and, where medically indicated, to refer the patient for treatment services.

The Committee amendment therefore requires that this medical examination include an assessment of the immunization status for all applicants for legalization. This assessment is not intended to

serve as a barrier to legalization: the Committee amendment does not require an alien to be immunized. Although lack of immunization should not be construed as an excludable condition, the Committee amendment does not alter the current statutory requirement that the presence of a dangerous contagious disease is a ground for exclusion. The Committee's intent is to promote appropriate voluntary immunization. Potential applicants, and particularly children, should be encouraged by the examining physician to update their immunization status where deficiencies are noted or a documented history of immunization or disease is unavailable. Information on the availability of publicly provided or publicly assisted immunization programs should be provided to the alien. The immunizations to which the Committee refers are those that are commonly administered during early childhood and generally required for attendance in schools.

The Committee amendment also specifies that the medical examination performed be appropriate and conform to generally accepted professional standards of medical practice. In so specifying, the Committee does not intend to require two examinations, one to identify excludable medical conditions, and one to assess health status. The Committee recognizes that the primary purpose of this medical examination is to determine whether there is any basis for exclusion of the individual on medical grounds. Indeed, the Committee does not intend to require a comprehensive physical examination for all diseases and disorders. Rather, the Committee intends that, in carrying out this limited examination, physicians conform to accepted standards of medical practice. Testimony presented to the Committee suggests that potentially inappropriate screening procedures are in common use, even though other techniques which present less risk to the patient are available (e.g., x-rays rather than skin tests for tuberculosis). The Committee expects the Public Health Service and examining physicians to review their screening techniques, practices, and diagnoses to ensure that they are neither unnecessarily costly nor reflective of outdated medical practice or theory.

It is the understanding of the Committee that it is customary for the INS to designate a list of the physicians in each community who may perform these medical examinations, and that the alien is allowed to choose from among those listed. Under the bill's legalization provisions, the demand for medical examinations can be expected to increase substantially in some communities. The Committee intends that the INS, in revising its designations to accommodate this demand, will include qualified public clinics and hospitals among the approved providers. The Committee expects that inclusion of these facilities will increase the accessibility of these examinations to aliens applying for legalization, and will promote the voluntary immunization of these applicants through referrals to public immunization clinics.

DENIAL OF MEDICAID ELIGIBILITY TO LEGALIZED ALIENS

Current Health Care Financing Administration regulations limit Medicaid coverage to aliens who are otherwise eligible for benefits (i.e., who meet the applicable income, resource, and categorical

tests) and who are lawfully admitted for permanent residence or permanently residing in the U.S. under color of law. A U.S. District Court has recently held these regulation invalid, *Lewis v. Gross*, No. CV-79-1740 (E.D.N.Y., July 14, 1986). The Aid to Families with Dependent Children (AFDC) program, and the Supplemental Security Income (SSI) program, both statutorily limit eligibility for cash assistance benefits to otherwise qualified aliens who are lawfully admitted for permanent residence or otherwise permanently residing in the U.S. under color of law.

As reported by the Committee on the Judiciary, the bill would create a new category of aliens residing in the U.S. "under color of law:" those whose immigration status is adjusted to that of an alien lawfully admitted for temporary and, subsequently, permanent residence under the legalization provisions of section 201. Under current law, these legalized aliens, if otherwise qualified, would be eligible for Medicaid benefits. However, the bill provides that, for 5 years after the date on which an otherwise eligible alien is granted lawful temporary resident status under the legalization program, he or she is ineligible for Medicaid benefits. Five groups of otherwise eligible aliens are protected from this 5-year disqualification: (1) Cuban and Haitian entrants; (2) aged, blind, and disabled individuals (as defined for SSI purposes); (3) children under 18; (4) pregnant women (for pregnancy-related services only); and (5) aliens needing emergency services. The bill supersedes any Medicaid State plan requirements to the extent required to restrict Medicaid benefits to the unprotected legalized aliens and expressly permits States or localities to restrict such coverage to the same extent.

The Committee amendment revises the bill so as to clarify that the legalized aliens who are entitled to Medicaid coverage under the terms of the 5 exceptions listed above must be otherwise eligible. This means that the alien must meet the income, resource, and categorical requirements of the State in which he or she is applying. The Committee amendment also replaces the provision relating to supersession of State Medicaid plan requirements with language clarifying that those legalized aliens eligible for emergency services or pregnancy-related services are not also entitled to other covered services as a result of the comparability requirements of sections 1902(a)(10)(B) and (C) of the Social Security Act. (However, those otherwise eligible aliens who are aged, blind, disabled, children under 18, or Cuban-Haitian entrants would be entitled to all covered services). In addition, the Committee amendment further clarifies that, while an otherwise qualified alien legalized under this bill is in a temporary resident status, he or she, for purposes of Medicaid eligibility, is considered "permanently residing in the U.S. under color of law."

The Committee recognizes that while the 5-year disqualification period in the bill applies to AFDC benefits as well as Medicaid, there are no exceptions for AFDC coverage comparable to those provided for Medicaid. (Under the bill, otherwise eligible aged, blind, and disabled aliens would receive SSI cash assistance as well as Medicaid benefits). In taking up the bill, the Committee specifically considered and rejected an amendment that would have eliminated the bill's proposed exceptions for alien children under

18 and for pregnancy-related services. The Committee believes that basic public health considerations, including the well-established importance of early and adequate prenatal care for the health of mothers and babies, militates against the denial of payment for basic medical care on behalf of the low-income legalized alien population. The Committee wishes to stress that, whether or not an alien legalized under this bill is actually receiving cash assistance under the AFDC program, if he or she is otherwise eligible for Medicaid benefits and falls within one of the 5 categories protected from the 5-year disqualification, he or she is entitled to Medicaid coverage.

Some would argue that there should be no exceptions to the 5-year disqualification from Medicaid benefits on the grounds that these exceptions are too costly for the Federal and State governments. The Committee would first observe that, unlike cash assistance benefits, needed emergency care cannot legally be withheld in many States. The Congress recently enacted a requirement that all hospitals participating in Medicare which operate an emergency room examine and, where necessary, stabilize any individual requesting services, regardless of ability to pay. Women in active labor are specifically included among the individuals entitled to the protections of the Medicare screening and stabilization requirements. Thus, the Congress has attempted, through the Medicare program, to assure that no individual, regardless of ability to pay or immigration status, may be denied emergency medical care. Denial of eligibility for Medicaid will not—and should not—result in a denial of needed medical services. Instead, it will merely shift the cost of those medical services from the Federal and State governments to the provider, which in many cases is the local public hospital or clinic.

Evidence of the magnitude of this cost shift comes from a 1983 study of undocumented aliens treated by the New York City Health and Hospitals Corporation, which operates the nation's largest public hospital system, comprises of 11 acute care hospitals, 4 long-term care facilities, 6 community-based neighborhood centers and over 30 satellite clinics. The study found that HHC hospitals treat roughly 7000 undocumented aliens as short-stay (under 90 days) patients each year, over 80 percent of whom are admitted through the emergency rooms. Half of these patients (51%) are pregnant women, most of whom have not received adequate prenatal care and have come to the hospital to give birth or resolve a complication of pregnancy. The study estimated that the HHC hospitals lose about \$18 million each year in Medicaid revenues solely because of the immigration status of its short-stay alien patients. Obviously, these are funds that must be made up by local taxpayers.

In the Committee's view, it would be wholly inappropriate for the Federal government, which has exclusive control over our Nation's borders and its immigration policy, to leave the financial consequences of that policy solely to the States and localities. If the Congress elects to legalize certain undocumented aliens, it is incumbent upon it to acknowledge the Federal government's responsibility to help pay for the emergency services that hospitals must, as a matter of State law and Federal Medicare law, provide to

these individuals who are unable to pay. Medicaid, the Federal-State program that purchases basic health care for the poor, is one logical vehicle for fulfilling this responsibility. In the case of low-income alien children and pregnant women, it would be simply irrational, from a public health standpoint, to discourage access to needed primary care and pregnancy-related services by denying Medicaid coverage. In the case of the aged, blind, and disabled who are otherwise eligible for Medicaid, it would be unconscionable to deny them coverage for needed services.

STATE LEGALIZATION ASSISTANCE

As reported by the Committee on the Judiciary, section 204 of the bill directs the Secretary of HHS to reimburse each State, subject to amounts appropriated in advance, for 100 percent of the costs of "programs of public assistance" provided to any eligible alien who has been granted temporary permanent resident status under the bill's legalization provisions. The bill authorizes the appropriation of such sums as may be necessary over the period FY 1987 through FY 1991 for this purpose. "Programs of public assistance" are defined to include any existing State- or locally-funded programs which provide for cash, medical, or other assistance required in the interest of public health and which are generally available to the needy.

It is clear that the State (and, where applicable, local) share of Medicaid expenditures for eligible legalized aliens is fully reimbursable as a "program of public assistance." However, the status of traditional public health programs under the bill is less certain. Accordingly, the Committee amendment clarifies that the State and local costs of providing services through "programs of public health assistance" to aliens who have been legalized (or have applied on a timely basis) qualify for 100 percent reimbursement to the same extent as "programs of public assistance." The Committee amendment makes explicit that reimbursable "programs of public health assistance" include immunizations for immunizable diseases, testing and treatment for tuberculosis and sexually-transmitted diseases, and family planning services.

The Committee amendment would provide 100 percent Federal reimbursement for the State and local costs of providing public health services to aliens who have filed loan bona fide applications for legalization and are awaiting a determination, as well as those who have been granted temporary permanent resident status. The Committee recognizes that it is neither in the alien's nor the Nation's interest for localities to withhold such services, which are designed for the protection of the broader community, due to lack of funds until the INS has formally approved an adjustment of immigration status. The Committee does not expect that many undocumented aliens will file frivolous applications for legalization just to obtain public health services, but in those cases where this occurs, the Committee does not intend that Federal reimbursement be made.

Finally, the Committee amendment makes clear that, to the extent a State or local public health program has already received Federal funding to provide services specifically to these eligible le-

galized aliens, the costs of services provided to such individuals are not eligible for reimbursement under the bill's legalization assistance program. The Committee intends that Federal reimbursement for State legalization cost not duplicate Federal funds already expended under existing categorical and block grant programs for the eligible legalized population.

HEARINGS

The Committee's Subcommittee on Health and the Environment held one day of hearings on June 17, 1983, on the Immigration Reform and Control Act of 1983, H.R. 1510, the predecessor to H.R. 3810. Testimony was received from nine witnesses, with additional material submitted by three individuals and organizations.

Due to the extremely short period for which H.R. 3810 was referred and the press of other legislative matters, the Subcommittee did not have an opportunity to supplement this hearing record.

COMMITTEE CONSIDERATION

On July 29, 1986, the Committee met in open session and ordered reported the bill H.R. 3810, with amendment, by voice vote, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(1)(3)(A) of Rule XI of the Rules of the House of Representatives, the oversight findings and recommendations made by the Committee are reflected in the legislative report.

COMMITTEE ON GOVERNMENT OPERATIONS

Pursuant to clause 2 (1)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Operations.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes the amendments it has recommended will have no budget effect on the cost incurred in carrying out H.R. 3810 as reported by the Committee on the Judiciary.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 31, 1986.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared this cost estimate for amendments to H.R. 3810, the Immigration Control and Legalization Amendments Act of 1986, as ordered reported by the House Committee on Energy and Commerce

on July 29, 1986. H.R. 3810 was ordered reported by the House Committee on the Judiciary on June 25, 1986.

This estimate provides the spending impacts of the Committee on Energy and Commerce amendments to H.R. 3810. The original CBO estimate for H.R. 3810, as reported by the Committee on the Judiciary, is attached to provide background information. The table below shows the original estimate of H.R. 3810's impact on spending, the Committee on Energy and Commerce changes to spending, and the resulting estimated spending, revenue, and federal deficit totals for the bill as amended.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

[By fiscal year, in millions of dollars]

	1986	1987	1988	1989	1990	1991
Judiciary bill:						
Required budget authority/estimated authorization level	434	655	1,170	1,885	2,201	2,277
Estimated outlays		480	819	1,779	2,348	2,475
Energy and Commerce amendments:						
Required budget authority/estimated authorization level		(¹)	(¹)	(¹)	(¹)	(¹)
Estimated outlays		(¹)	(¹)	(¹)	(¹)	(¹)
Total spending:						
Required budget authority/estimated authorization level	434	655	1,170	1,885	2,201	2,277
Estimated outlays		480	819	1,779	2,348	2,475
Estimated revenues		70	166	54	54	.....
Net budget impact: Estimated net increase or decrease ((-)) in the deficit		410	653	1,725	2,294	2,475

¹ Less than \$500,000.

The Committee on Energy and Commerce reported four amendments to H.R. 3810, none of which are estimated by CBO to affect spending significantly.

Amendments were made to the System for Alien Verification of Eligibility (SAVE), which would require a number of federal benefit programs to check with the Immigration and Naturalization Service as to the resident status of aliens applying for program benefits. These amendments would permit a program or jurisdiction not to use SAVE if waivers were granted by Department Secretaries. Waivers could be given if alternative verification systems were found to be as effective or if the administrative costs of SAVE exceeded any estimated savings. Without knowing more about SAVE and the extent to which waivers might be granted, the CBO estimate assumed that savings and costs would be approximately offsetting. If the cost effectiveness of SAVE could be measured accurately and waivers granted accordingly, however, these amendments would be likely to result in federal budgetary savings.

The remaining amendments primarily clarified the bill's language concerning denial of Medicaid eligibility to aliens legalized under H.R. 3810, state legalization assistance for programs of public health, and required medical exams for aliens applying for legalization.

If you wish further details on this estimate, please call me or have your staff contact Janice Peskin (226-2820).

With best wishes.

Sincerely,

RUDOLPH G. PENNER.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the Committee makes the following statement with regard to the inflationary impact of the reported bill:

The Committee is unaware of any inflationary effects that might be associated with the amendments it has recommended. To the extent that these amendments will encourage early intervention in health problems, control communicable diseases, and assure adequate care for pregnant women and children, the Committee believes that the legislation may lower the long-term social and economic costs of preventable disability and disease.

AGENCY VIEWS

No agency views were received by the Committee on Energy and Commerce.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, except as shown below, are shown in part 1 of this report, filed by the Committee on the Judiciary on July 16, 1985. The differences between the bill as reported by the Committee and as reported by the Committee on the Judiciary are shown below using the following typographical devices (with "Judiciary" referring to the Committee on the Judiciary and "E&C" referring to the Committee on Energy and Commerce):

Existing law—

in which no change is proposed by Judiciary or E&C, printed in roman.

proposed to be omitted by both Judiciary and E&C, enclosed in black brackets, viz., [].

proposed to be omitted only by Judiciary (and not by E&C), printed in *linetype*.

proposed to be omitted only by E&C (and not by Judiciary), enclosed in black parentheses, viz., ().

New matter—

proposed to be inserted by both Judiciary and E&C, printed in *italic*.

proposed to be inserted only by Judiciary (and not by E&C), printed in *italic linetype*.

proposed to be inserted only by E&C (and not by Judiciary), printed in **boldface roman**.

IMMIGRATION AND NATIONALITY ACT

* * * * *

TITLE II—IMMIGRATION

* * * * *

CHAPTER 5—DEPORTATION; ADJUSTMENT OF STATUS

* * * * *

ADJUSTMENT OF STATUS OF CERTAIN ENTRANTS BEFORE JANUARY 1, 1982, TO THAT OF PERSON ADMITTED FOR LAWFUL RESIDENCE

SEC. 245A. (a) * * *

* * * * *

(d) WAIVER OF NUMERICAL LIMITATIONS AND CERTAIN GROUNDS FOR EXCLUSION.—

(1) * * *

(2) WAIVER OF GROUNDS FOR EXCLUSION.—In the determination of an alien's admissibility under subsections (a)(4)(A), (b)(1)(C)(i), and (b)(2)(B)—

(A) * * *

* * * * *

(C) MEDICAL EXAMINATION.—The alien shall be required, at the alien's expense, to meet the same requirements with respect to a medical examination as are required of aliens seeking entry into the United States as immigrants: to undergo such a medical examination (including a determination of immunization status) as is appropriate and conforms to generally accepted professional standards of medical practice.

* * * * *

(h) TEMPORARY DISQUALIFICATION OF NEWLY LEGALIZED ALIENS FROM RECEIVING CERTAIN PUBLIC WELFARE ASSISTANCE—

(1) IN GENERAL.—During the five-year period beginning on the date an alien was granted lawful temporary resident status under subsection (a), and notwithstanding any other provision of law—

(A) except as provided in ~~paragraph (2)~~ paragraphs (2) and (3), the alien is not eligible for—

(i) any program of financial assistance furnished under Federal law (whether through grant, loan, guarantee, or otherwise) on the basis of financial need, as such programs are identified by the Attorney General in consultation with other appropriate heads of the various departments and agencies of Government,

(ii) medical assistance under a State plan approved under title XIX of the Social Security Act, and

(iii) assistance under the Food Stamp Act of 1977; and

(B) a State or political subdivision therein may, to the extent consistent with subparagraph (A) and paragraphs (2) and (3), provide that the alien is not eligible for the programs of financial assistance or for medical assistance described in subparagraph (A)(ii) furnished under the law of that State or political subdivision.

(2) EXCEPTIONS FOR CERTAIN INDIVIDUALS.—Paragraph (1) shall not apply—

(A) to a Cuban and Haitian entrant (as defined in paragraph (1) or (2)(A) of section 501(e) of Public Law 96-422, as in effect on April 1, 1983), or

(B) in the case of assistance furnished to an alien who is an aged, blind, or disabled individual (as defined in section 1614(a)(1) of the Social Security Act; or.

(C) in the case of medical assistance (i) for care and services provided to an alien who is under 18 years of age; (ii) for emergency services (as defined for purposes of section 1916(a)(2)(D) of the Social Security Act) or (iii) for services described in section 1916(a)(2)(B) of such Act (relating to services for pregnant women).

(3) RESTRICTED MEDICAID BENEFITS.—

(A) CLARIFICATION OF ENTITLEMENT.—Subject to the restrictions under subparagraph (B), for the purpose of providing aliens with eligibility to receive medical assistance—

(i) paragraph (1) shall not apply,

(ii) aliens who would be eligible for medical assistance but for the provisions of paragraph (1) shall be deemed, for purposes of title XIX of the Social Security Act, to be so eligible, and

(iii) aliens lawfully admitted for temporary residence under this section, such status not having changed, shall be considered to be permanently residing in the United States under color of law.

(B) RESTRICTION OF BENEFITS.—

(i) LIMITATION TO EMERGENCY SERVICES AND SERVICES FOR PREGNANT WOMEN.—Notwithstanding any provision of title XIX of the Social Security Act (including subparagraphs (B) and (C) of section 1902(a)(10) of such Act), aliens who, but for subparagraph (A), would be ineligible for medical assistance under paragraph (1), are only eligible for such assistance with respect to—

(I) emergency services (as defined for purposes of section 1916(a)(2)(D) of the Social Security Act), and

(II) services described in section 1916(a)(2)(B) of such Act (relating to service for pregnant women).

(ii) NO RESTRICTION FOR EXEMPT ALIENS AND CHILDREN.—The restrictions of clause (i) shall not apply to aliens who are described in paragraph (2) or who are under 18 years of age.

(C) DEFINITION OF MEDICAL ASSISTANCE.—In this paragraph, the term “medical assistance” refers to medical assistance under a State plan approved under title XIX of the Social Security Act.

(4) TREATMENT OF CERTAIN PROGRAMS.—Assistance furnished under any of the following provisions of law shall not be construed to be financial assistance described in paragraph (1)(A)(i):

(4) (5) *ADJUSTMENT NOT AFFECTING FASCELL-STONE BENEFITS.*—For the purpose of section 501 of the Refugee Education Assistance Act of 1980 (Public Law 96-122), assistance shall be continued under such section with respect to an alien without regard to the alien's adjustment of status under this section.

(6) *MODIFICATION OF MEDICAID REQUIREMENTS.*—The eligibility, comparability, and any other State plan requirements of title XIX of the Social Security Act are superseded to the extent required to restrict the medical assistance in the manner described in this subsection. The Secretary of Health and Human Services, in coordination with the Attorney General, shall promulgate regulations in order to carry out this subsection.

* * * * *



IMMIGRATION CONTROL AND LEGALIZATION AMENDMENTS ACT OF 1986

AUGUST 5, 1986.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. DE LA GARZA, from the Committee on Agriculture,
submitted the following

R E P O R T

[To accompany H.R. 3810]

[Including cost estimate of the Congressional Budget Office]

The Committee on Agriculture, to whom was referred the bill (H.R. 3810) to amend the Immigration and Nationality Act to revise and reform the immigration laws, and for other purposes, having considered the same and the amendment thereto reported by the Committee on the Judiciary, report those provisions of the bill, as amended, within the jurisdiction of the Committee with amendments and recommend that the provisions as amended be agreed to.

The amendments (stated in terms of page and line numbers of the bill as reported by the Committee on the Judiciary) are as follows:

AMENDMENT NO. 1

Page 43, after line 2, insert the following new section (and insert a corresponding item in the table of contents):

SEC. 114. RESTRICTING WARRANTLESS ENTRY IN THE CASE OF OUTDOOR AGRICULTURAL OPERATIONS.

Section 287 (8 U.S.C. 1357) is amended by adding at the end the following new subsection:

“(d) Notwithstanding any other provision of this section other than paragraph (3) of subsection (a), an officer or employee of the Service may not enter without the consent of the owner (or agent thereof) or a properly executed warrant onto the premises of a farm or other outdoor agricul-

tural operation for the purpose of interrogating a person believed to be an alien as to the person's right to be or to remain in the United States."

AMENDMENT NO. 2

Page 61, after line 14, insert the following new subsection:

(d) GAO REPORTS.—

(1) REPORT ON CURRENT PILOT PROJECTS.—The Comptroller General shall—

(A) examine current pilot projects relating to the System for Alien Verification of Eligibility (SAVE) operated by, or through cooperative agreements with, the Immigration and Naturalization Service, and

(B) report, not later than October 1, 1987, to Congress and to the Commissioner of the Immigration and Naturalization Service concerning the effectiveness of such projects and any problems with the implementation of such projects, particularly as they may apply to implementation of the system referred to in subsection (c)(1).

(2) REPORT ON IMPLEMENTATION OF VERIFICATION SYSTEM.—The Comptroller General shall—

(A) monitor and analyze the implementation of such system,

(B) report to Congress and to the appropriate Secretaries described in subsection (c)(4)(D)(ii), by no later than April 1, 1989, on such implementation, and

(C) include in such report such recommendations for changes in the system as may be appropriate.

Page 61, line 7, strike "The amendments" and insert "Except as provided in paragraph (4), the amendments".

Page 61, after line 10, insert the following new paragraph (and redesignate the succeeding paragraph accordingly):

(4) USE OF VERIFICATION SYSTEM NOT REQUIRED FOR A PROGRAM IN CERTAIN CASES.—

(A) REPORT TO RESPECTIVE CONGRESSIONAL COMMITTEES.—With respect to each covered program (as defined in subparagraph (D)(i), each appropriate Secretary shall examine and report to the appropriate Committees of the House of Representatives and of the Senate, by not later than April 1, 1988, concerning whether (and the extent to which)—

(i) the application of the amendments made by subsection (a) to the program is cost-effective and otherwise appropriate, and

(ii) there should be a waiver of the application of such amendments under subparagraph (B).

The amendments made by subsection (a) shall not apply with respect to a covered program until 6 months after the date of receipt of such report with respect to the program.

(B) **WAIVER IN CERTAIN CASES.**—If, with respect to a covered program, the appropriate Secretary determines, on the Secretary's own initiative or upon an application by an administering entity and based on such information as the Secretary deems persuasive (which may include the results of the report required under subsection (d)(1) and information contained in such an application), that—

(i) the appropriate Secretary or the administering entity has in effect an alternative system of immigration status verification which—

(I) is as effective and timely as the system otherwise required under the amendments made by subsection (a) with respect to the program, and

(II) provides for at least the hearing and appeals rights for beneficiaries that would be provided under the amendments made by subsection (a), or

(ii) the costs of administration of the system otherwise required under such amendments exceed the estimated savings,

such Secretary may waive the application of such amendments to the covered program to the extent (by State or other geographic area or otherwise) that such determinations apply.

(C) **BASIS FOR DETERMINATION.**—A determination under subparagraph (B)(ii) shall be based upon the appropriate Secretary's estimate of—

(i) the number of aliens claiming benefits under the covered program in relation to the total number of claimants seeking benefits under the program,

(ii) any savings in benefit expenditures reasonably expected to result from implementation of the verification program, and

(iii) the labor and nonlabor costs of administration of the verification system,

the degree to which the Immigration and Naturalization Service is capable of providing timely and accurate information to the administering entity in order to permit a reliable determination of immigration status, and such other factors as such Secretary deems relevant.

(D) **DEFINITIONS.**—In this paragraph:

(i) The term "covered program" means each of the following programs:

(I) The aid to families with dependent children program under part A of title IV of the Social Security Act.

(II) The medicaid program under title XIX of the Social Security Act.

(III) The supplemental security income program under title XVI of the Social Security Act.

(IV) Any State program under a plan approved under title I, X, XIV, or XVI of the Social Security Act.

(V) The unemployment compensation program under section 3304 of the Internal Revenue Code of 1954.

(VI) The food stamp program under the Food Stamp Act of 1977.

(VII) The programs of financial assistance for housing subject to section 214 of the Housing and Community Development Act of 1980.

(VIII) The program of grants, loans, and work assistance under title IV of the Higher Education Act of 1965.

(ii) The term "appropriate Secretary" means, with respect to the covered program described in—

(I) subclauses (I) through (IV) of clause (i), the Secretary of Health and Human Services;

(II) clause (i)(V), the Secretary of Labor;

(III) clause (i)(VI), the Secretary of Agriculture;

(IV) clause (i)(VII), the Secretary of Housing and Urban Development; and

(V) clause (i)(VIII), the Secretary of Education.

(iii) The term "administering entity" means, with respect to the covered program described in—

(I) subclause (I), (II), (IV), (V), or (VI) of clause (i), the State agency responsible for the administration of the program in a State;

(II) clause (i)(III), the Secretary of Health and Human Services;

(III) clause (i)(VII), the Secretary of Housing and Urban Development, a public housing agency, or another entity that determines the eligibility of an individual for financial assistance; and

(IV) clause (i)(VIII), an institution of higher education involved.

BRIEF EXPLANATION OF COMMITTEE AMENDMENTS

OUTDOOR AGRICULTURAL OPERATIONS

Officers of the Immigration and Naturalization Service will be prohibited from entering onto the premises of a farm or other outdoor agricultural operation to question a person believed to be an alien unless they have (1) consent of the owner or his agent or (2) a properly executed warrant. (Comm. Amdt. no. 1.)

USE OF VERIFICATION SYSTEM AND REPORTS

With respect to the bill's proposed system under which States will be required to verify the immigration status of aliens applying for specified public assistance programs—

(1) the Comptroller General will be required to study and report (by October 1, 1987) on current verification pilot projects, and (by April 1, 1989) on the Service's implementation of verification requirements under the bill;

(2) the Secretaries of the Federal departments overseeing the assistance programs will be required to report to the appropriate committees of Congress, by April 1, 1988, concerning whether the proposed State verification system is cost-effective and otherwise appropriate and whether the State verification requirements under the proposed system should be waived; and

(3) the Secretaries will be authorized to waive the applicability of the proposed State verification system to the assistance program involved, if (a) there is in effect an alternative system of verification that is effective and provides adequate appeal rights, or (b) the costs of the proposed system exceeds estimated savings under it.

The public assistance programs involved are the aid to families with dependent children program, medicaid, the supplemental security income program, certain State programs under the Social Security Act, the unemployment compensation program, the food stamp program, certain housing programs, and Higher Education Act assistance programs. (Comm. Amdt. no. 2.)

PURPOSE AND NEED

The Committee on Agriculture supports the provisions of H.R. 3810, as reported by the Committee on the Judiciary, on those matters within the Agriculture Committee's jurisdiction. Those matters include sections 101 and 112 (employee sanctions), 201 (benefits for aliens), 301 (H-2 reform), 302 and 303 (special agricultural workers program), (Commission), 305 (legal assistance to H-2A workers), 402 (Secretaries' report), and 403 and 404 (reports).

The Committee is pleased that a compromise agreement has been reached by Members of the Judiciary Committee and various other authorizing committees with regard to the H-2 agricultural program and the special agricultural workers program for perishable commodities. However, a provision in H.R. 3810, as introduced, to require the consent of the owner or a warrant prior to entering agricultural fields to interrogate suspected illegal aliens, was deleted during Judiciary Committee consideration of the bill. The Com-

mittee on Agriculture recommends that this provision be restored. Additionally, the Committee recommends, in conjunction with several other committees, improvements to that part of the legislation providing for a systematic alien verification for entitlements (SAVE) program for various Federal public assistance programs.

OUTDOOR AGRICULTURAL OPERATIONS

The Fourth Amendment to the Constitution forbids unreasonable searches and seizures, giving rise to a presumption that searches and seizures must be under a warrant issued by a magistrate. However, through the course of the years, the Supreme Court has recognized exceptional situations in which a warrant is not required. One of these exceptions is the so-called "open fields" doctrine that allows law enforcement officers to search an open field without a warrant.

Since *Hester v. United States*, 265 U.S. 57, in which this exception was recognized, the Supreme Court has in a number of cases reexamined and reiterated the *Hester* doctrine: there is no Constitutional protection against search and seizure in an open field.

Since Immigration and Naturalization Service policy treats agricultural lands as "open fields," there is now no requirement for Service enforcement officials to obtain a warrant prior to entering farms or ranches. However, this policy is unlike the policy applied to other places of business. Also, under this policy, one of the basic rights provided under the Constitution, the right of people to be secure against unreasonable searches and seizures, is being denied to an important segment of our society—farmers and ranches.

Further, according to the Department of Labor (based on the limited data available), of the millions of undocumented aliens in the United State, it is likely that most of them are in the labor market. However, of the 1.3 million apprehensions by the Immigration and Naturalization Service last year, only 110 thousand of these persons were actively employed and 72 percent of those employed were in agriculture. With the apparent large number of other undocumented aliens working in other industries, it is obvious that the Service's enforcement efforts are focused primarily in those areas easiest to access.

In addition, the surprise raids by the Service, in the Committee's view, have unduly harrassed agricultural employers and employees and, in a number of situations, have jeopardized the lives of workers. Such raids have caused damage to crops in many instances and unnecessary disruptions in employment. Work stoppages are costly to the farmer, especially in perishable commodities, when agricultural products cannot be harvested timely.

The Committee amendment no. 1 would require that a Service enforcement officer may not enter an outdoor agricultural operation for the purpose of questioning an alien without the consent of the owner or a search warrant.

This proposal has been carefully designed to ensure applicability only to agricultural operations. It ensures agricultural employers and employees equal protection under the law.

The amendment will not require a warrant in other cases relating to the arrest of an alien who appears to be in violation of the

Immigration and Nationality Act and is likely to escape before a warrant can be obtained. Neither does the amendment address warrantless entry to apprehend those committing a felony. Nor would the Committee amendment prevent immigration officers from entering property within 25 miles of our national borders without a warrant, for purposes of border patrol.

It should be noted that the Administration opposes the amendment because it is the view of the Immigration and Naturalization Service that the requirement for a warrant would curtail the enforcement activities of that agency. However, the Committee has not received convincing evidence to support the view that search warrant requirements or consent of the owner for entry into open agricultural lands would unduly hamper enforcement efforts.

The House of Representatives had declared its interest, in past immigration reform legislation, in correcting this injustice to farmers.

In 1984, the House Judiciary Committee reported H.R. 1510, the Immigration Reform and Control Act of 1983, which included a similar provision. A vote on the House floor on June 13, 1984, to strike the language restricting warrantless entry was rejected by a substantial margin (133 ayes to 285 noes).

The ensuing House-Senate conference on that bill crafted a compromise amendment to restrict entry on farm or other agricultural operations unless there was consent of the owner or a properly executed warrant. However, no final agreement on other provisions of the bill was reached, so that Congress was unable to finalize its work on immigration reform legislation that year.

H.R. 3810, as introduced by Chairman Rodino of the Committee on the Judiciary, contained a provision identical to the Committee on Agriculture amendment.

A wide range of organizations, including farm, civil liberties, and labor organizations, support the amendment.

The Committee on Agriculture amendment, which is the same as that adopted by the House-Senate conferences in 1984, will ensure that agricultural employers and employees receive the clear and equal protections of the law currently accorded others against unreasonable searches and seizures.

USE OF VERIFICATION SYSTEM AND REPORTS

A major concern about the legalization procedures in the immigration reform proposals that Congress has considered in the past has been the possibility that Federal and State public assistance costs would be increased if persons not eligible for benefits under the legalization procedures applied for benefits and States were unable to verify whether these persons were eligible.

To avoid erroneous payments to persons ineligible for benefits, H.R. 3810, as reported by the Committee on the Judiciary, would require States beginning October 1, 1988, to verify whether alien applicants for certain public assistance programs are in a lawful immigration status and thus eligible for participation in the programs. This procedure is known as systematic alien verification for entitlements program (SAVE). Programs involved in SAVE would be: aid to families with dependent children (AFDC), medicaid, un-

employment compensation, certain State programs under the Social Security Act, food stamps, supplemental security income, housing assistance, and higher education assistance.

The Committee on Agriculture supports the SAVE procedures as an important safeguard to hold down public assistance costs. At the same time, the Committee wants to ensure that SAVE is implemented in a way that would not impose administrative burdens either on Federal agencies or the States unless there was some assurance that savings would result.

To ensure that the savings from avoiding erroneous benefit payments would exceed increased administrative costs the Federal Government and States would incur from implementing SAVE, the Agriculture Committee has approved an amendment to the SAVE provision to provide the following:

First, reports by the General Accounting Office would be required on both the pilot projects currently under way and the verification system that would be implemented starting in fiscal year 1989. The report on the pilot projects would be due not later than October 1, 1987. The report on implementation of SAVE would be due no later than April 1, 1989; and

Second, before SAVE could be implemented for specific programs in a State or geographic area, the Secretary of the administering Federal department would have to report whether SAVE would be cost-effective and otherwise appropriate and whether the SAVE provisions should be waived. This report would be submitted to the authorizing committees of Congress with jurisdiction over the program or programs affected in SAVE no later than April 1, 1988. SAVE could not be implemented for a given program until six months after receipt by Congress of the report. The Secretary with authority over a program or programs affected by SAVE could waive the application of the SAVE provisions in a State or other geographic area if it is determined that—

- (1) there is in effect an alternative system of immigration status verification as effective and timely as SAVE; or
- (2) the cost of administering SAVE would exceed the estimated savings.

SECTION-BY-SECTION ANALYSIS OF THE COMMITTEE AMENDMENTS

AMENDMENT NO. 1—OUTDOOR AGRICULTURAL OPERATIONS

Committee amendment No. 1 will add a new section 114 to H.R. 3810, as reported by the Committee on the Judiciary. New section 114 would add a new subsection (d) to section 287 of the Immigration and Nationality Act.

Under current law, section 287, in subsection (a), provides that officers and employees of the Immigration and Naturalization Service have the power without warrant to—

- (1) interrogate any alien or person believed to be an alien as to his right to be in the United States (paragraph (1));
- (2) arrest any alien crossing the border illegally in his presence, or any alien in the United States he has reason to believe is violating the immigration laws and is likely to escape before an arrest warrant can be issued (paragraph (2));

(3) within a reasonable distance from the border, board and search vessels and other conveyances (paragraph (3));

(4) within 25 miles of the border, have access to private lands (but not dwellings) for the purpose of patrolling the border (paragraph (3));

(5) make arrests for any felony cognizable under the immigration laws if he has reason to believe that the person arrested is guilty of the felony and there is a likelihood that the person will escape before an arrest warrant can be issued (paragraph (4)).

Subsection (b) of section 287 authorizes officers and employees of the Service to administer oaths and to take and consider evidence concerning matters that are material or relevant to enforcing the Act. It also establishes penalties for false oaths. Subsection (c) authorizes designated officers or employees of the Service to search persons seeking admission to the United States and their personal effects.

Under new subsection (d), to be added under Committee amendment No. 1, officers and employees of the Service would be prohibited (except as described below) from entering the premises of a farm or other outdoor agricultural operation, without consent of the owner or his agent or a properly executed warrant, for the purpose of interrogating a person believed to be an alien as to the person's right to be or to remain in the United States. The prohibition would not apply to activities empowered under paragraph (3) of subsection (a), that is, searches of conveyances within a reasonable distance of the border and access to private lands within 25 miles of the border as a part of border patrol.

AMENDMENT NO. 2—USE OF VERIFICATION SYSTEM AND REPORTS

Committee amendment No. 2 will add a new subsection (d) to, and revise subsection (c) of, section 121 of H.R. 3810, as reported by the Committee on the Judiciary, relating to verification of alien status under certain programs.

Subsection (a) of section 121, as reported by the Judiciary Committee, will amend section 1137 of the Social Security Act and other provisions of law to require the States to verify the immigration status of aliens applying under certain public assistance programs, including aid to families with dependent children (AFDC), medicaid, unemployment compensation, food stamps, supplemental security income (SSI), housing assistance, and title IV educational assistance. Under subsection (a), alien applicants will have the opportunity to submit evidence as to immigration status without denial or termination of benefits until evidence of status has been verified. Also, States will not be liable for the consequences or verification.

Subsection (b) of section 121, as reported by the Judiciary Committee, will amend the assistance program statutes involved to provide for 100 percent reimbursement to the States for implementing the status verification system to be established under subsection (a).

Subsection (c) of section 121, as reported by the Judiciary Committee, in paragraph (1), will require the Immigration and Natural-

ization Service to implement its system for alien status verification, by October 1, 1987. It also will prohibit the use of the Service's system for certain enforcement purposes, and require that it be implemented in a nondiscriminatory manner. Subsection (c), in paragraph (2), will make the State reimbursement provisions of subsection (b) effective October 1, 1987. Subsection (c), in paragraph (3), provides that the States will have until October 1, 1988, to comply with requirements imposed under subsection (a). Subsection (c), in paragraph (4), will authorize funding for the Service to carry out section 121.

Under new subsection (d), to be added by Committee amendment No. 2, two studies and reports by the Comptroller General will be required, as follows:

(1) *Report on current pilot projects.*—The Comptroller General will be required to—

(A) examine current pilot projects relating to the system for alien verification of eligibility (SAVE) (the matter addressed by section 121) operated by, or through cooperative agreements with, the Service, and

(B) report, not later than October 1, 1987, to Congress and to the Commissioner of the Immigration and Naturalization Service concerning the effectiveness of such projects and any problems with the implementation of such projects, particularly as they may apply to implementation of the Service's verification system referred to in paragraph (1) of subsection (c).

(2) *Report on implementation of verification system.*—The Comptroller General will be required to—

(A) monitor and analyze the implementation of the Service's verification system,

(B) report to Congress and to the Federal departmental Secretaries that oversee the assistance programs covered by subsection (a), by not later than April 1, 1989, on such implementation; and

(C) include in such report any recommendations for change in the Service's system as may be appropriate.

Committee amendment No. 2 will amend paragraph (3) of subsection (c), as reported by the Judiciary Committee, to provide that the October 1, 1988, effective date for the amendments made by subsection (a) and for the requirements applicable to the States thereunder will be subject to the provisions of new paragraph (4).

Committee amendment No. 2 also will add, to subsection (c), a new paragraph (4), entitled "Use of verification system not required for a program in certain cases". Current paragraph (4) will be redesignated as paragraph (5).

Under new paragraph (4), with respect to each covered program (as defined in paragraph (4) and described below), each appropriate Secretary (as defined in paragraph (4) and described below) must examine and report to the appropriate Committees of the House of Representatives and of the Senate, by not later than April 1, 1988, concerning whether (and the extent to which)—

(1) the application of the amendments made by subsection (a) to the program is cost-effective and otherwise appropriate, and

(2) there should be a waiver of the application of such amendments.

The amendments made by subsection (a) would not apply with respect to a covered program until six months after the date of receipt of such report with respect to the program.

Also under new paragraph (4), if, with respect to a covered program, the appropriate Secretary determines, on the Secretary's own initiative or an application by an administering entity (as defined in paragraph (4) and described below) and based on information the Secretary deems persuasive (which may include the results of the Comptroller General's report on current status verification projects to be required under new subsection (d) and information contained in the application), that—

(1) the appropriate Secretary of the administering entity has in effect an alternative system of immigration status verification that—

(A) is as effective and timely as the system otherwise required under the amendments made by subsection (a) with respect to the program; and

(B) provides for at least the hearing and appeals rights for beneficiaries that would be provided under the amendments made by subsection (a), or

(2) the costs of administration of the System otherwise required under such amendments exceed the estimated savings, the Secretary could waive the application of such amendments to the covered program to the extent (by State or other geographic area or otherwise) that such determinations apply.

A determination as to whether the costs of administering a subsection (a) system will exceed estimated savings would be based on—

(1) the appropriate Secretary's estimate of—

(A) the number of aliens claiming benefits under the covered program in relation to the total number of claimants seeking benefits under the program,

(B) any savings in benefit expenditures reasonably expected to result from implementation of the verification program, and

(C) the labor and nonlabor costs of administration of the verification system;

(2) the degree to which the Immigration and Naturalization Service is capable of providing timely and accurate information to the administering entity to permit a reliable determination of immigration status; and

(3) other factors the Secretary deems relevant.

Paragraph (4) defines the term "covered program" to mean each of the following programs:

(1) The aid to families with dependent children program under Part A of title IV of the Social Security Act.

(2) The medicaid program under title XIX of the Social Security Act.

(3) The supplemental security income program under title XVI of the Social Security Act.

(4) Any State program under a plan approved under title I, X, XIV, or XVI of the Social Security Act.

(5) The unemployment compensation program under section 3304 of the Internal Revenue Code of 1954.

(6) The food stamp program under the Food Stamp Act of 1977.

(7) The programs of financial assistance for housing subject to section 214 of the Housing and Community Development Act of 1980.

(8) the program of grants, loans, and work assistance under title IV of the Higher Education Act of 1965.

Paragraph (4) defines the term "appropriate Secretary" to mean—

(1) the Secretary of Health and Human Services with respect to the aid to families with dependent children program, medic-aid program, supplemental security income program, and State programs under title I, X, XIV, or XVI or the Social Security Act;

(2) the Secretary of Labor with respect to the unemployment compensation program;

(3) the Secretary of Agriculture with respect to the food stamp program;

(4) the Secretary of Housing and Urban Development with respect to the programs of financial assistance for housing; and

(5) the Secretary of Education with respect to the program under Higher Education Act of 1965.

Paragraph (4) defines the term "administering agency" to mean—

(1) the State agency responsible for the administration of the program in a State, with respect to the aid to families with dependent children, medicaid, Social Security Act, unemployment compensation, and food stamp programs;

(2) the Secretary of Health and Human Services with respect to the supplemental security income program;

(3) the Secretary of Housing and Urban Development, a public housing agency, or another entity that determines the eligibility of an individual for financial assistance, with respect to the housing programs; and

(4) the institution of higher education involved, with respect to the Higher Education Act program.

COMMITTEE CONSIDERATION

On July 31, 1986, the Committee on Agriculture met, a quorum being present, to consider H.R. 3810, the Immigration Control and Legalization Amendments Act of 1986.

Chairman de la Garza noted that the Committee on Agriculture did not conduct public hearings on the legislation this year in view of previous hearings on immigration reform legislation in the last Congress. He pointed out the Members of the Committee had been working an ad hoc basis with Members of the Committee on the Judiciary in expediting action on the legislation and in promoting and protecting agricultural interests.

Congressman Panetta was recognized to discuss that section of the bill relating to temporary agricultural workers. He advised the Committee that compromise on the H-2 and special agricultural worker provisions of the bill had been reached among members from the committees of the House representing agricultural, labor,

and law enforcement jurisdiction areas. He stated that the compromise was endorsed by a broad cross-section of groups including the Farm Labor Alliance, the American Farm Bureau Federation, the H-2 Coalition, the AFL-CIO, as well as number of civil rights groups.

Congressman Morrison spoke briefly on past efforts of the Committee to provide, in immigration reform legislation, appropriate measures to protect the supply of workers in agriculture.

The Committee then proceeded to consider amendments to H.R. 3810, as reported by the Committee on the Judiciary.

Congressman Panetta offered an amendment on behalf of himself, and Congressmen Morrison and Coelho, to require consent of the owner or a search warrant before Immigration and Naturalization Service enforcement officers could enter a farm or other outdoor agricultural operation to interrogate any person believed to be an alien as to his right to be in the United States. He stated that this amendment had been part of the original bill but that it had been deleted by the Judiciary Committee during its consideration of H.R. 3810. He further noted that the amendment was needed to provide protection to farmers and farm employees under the Fourth Amendment of the Constitution and to prevent certain unwarranted tactics by the Service that jeopardize the lives of farmworkers.

Mr. Morrison discussed the inequity of having to secure a warrant for outdoor agricultural operations as opposed to any other place of employment. He and several other Members of the Committee expressed strong support for the amendment.

Mr. Volkmer expressed concern that the amendment did not address what was to be required of the Immigration and Naturalization Service to obtain a warrant. Mr. Staggers commented on the difficulty of describing an agricultural field to obtain a warrant. Other discussion of the amendment ensued, and counsel explained that the amendment required consent of the owner or warrant only where interrogation, not arrest, was concerned. The amendment was agreed to by voice vote.

Mr. Panetta offered a further amendment to that section of the bill relating to the systematic alien verification for entitlements program (SAVE). Under the legislation, States would be required to verify whether alien applicants for aid to families with dependent children, medicaid, unemployment compensation, State assistance under the Social Security Act, food stamps, supplemental security income, housing assistance, and higher education assistance are in a lawful immigration status and thus eligible to participate in the program. He noted that other authorizing Committees of the House had endorsed this or similar language. After an explanation of the provision, the Committee approved the amendment by voice vote.

Mr. Lewis was recognized to offer an amendment to the legalization section of the bill to change the date for temporary resident status from January 1, 1982, to January 1, 1978. In the discussion of the amendment that followed, Chairman de la Garza noted Committee jurisdictional problems and offered assistance of the Committee, if possible, in allowing Mr. Lewis to offer his amendment on the House floor. The amendment was then withdrawn.

A motion to favorably report the bill, with amendments to the bill as reported by the Committee on the Judiciary, was offered; and the Committee approved the motion by a voice vote.

ADMINISTRATION POSITION

At the time of the filing of this report, the Committee had not received a report from the Administration concerning H.R. 3810, as amended by the Committee on Agriculture.

BUDGET ACT COMPLIANCE (SECTION 308 AND SECTION 403)

The provisions of clause 2(1)(3)(B) of Rule XI of the Rules of the House of Representatives and section 308(a) of the Congressional Budget Act of 1974 (relating to estimates of new budget authority or new or increased tax expenditures) are not considered applicable. The estimate and comparison required to be prepared by the Director of the Congressional Budget Office under clause 2(1)(3)(C) of Rule XI of the Rules of the House of Representatives and section 403 of the Congressional Budget Act of 1974 submitted to the Committee prior to the filing of this report are as follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 1, 1986.

Hon. E DE LA GARZA,
Chairman, Committee on Agriculture, U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared this cost estimate for amendments to H.R. 3810, the Immigration Control and Legalization Amendments Act of 1986, as ordered reported by the House Committee on Agriculture on July 31, 1986. H.R. 3810 was ordered reported by the House Committee on the Judiciary on June 25, 1986.

This estimate provides the spending impacts of the Committee on Agriculture amendments to H.R. 3810. The original CBO estimate for H.R. 3810, as reported by the Committee on the Judiciary, is attached to provide background information. The table below shows the original estimate of H.R. 3810's impact on spending, the Committee on Agriculture changes to spending, and the resulting estimated spending, revenue, and federal deficit totals for the bill as amended.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

[By fiscal year, in millions of dollars]

	1986	1987	1988	1989	1990	1991
Judiciary bill:						
Required budget authority/estimated authorization level	434	655	1,170	1,885	2,201	2,277
Estimated outlays.....		480	819	1,779	2,348	2,475
Agriculture amendments:						
Required budget authority/estimated authorization level		(1)	(1)	(1)	(1)	(1)
Estimated outlays.....		(1)	(1)	(1)	(1)	(1)
Total spending:						
Required budget authority/estimated authorization level...	434	655	1,170	1,885	2,201	2,277

ESTIMATED COST TO THE FEDERAL GOVERNMENT—Continued

(By fiscal year, in millions of dollars)

	1986	1987	1988	1989	1990	1991
Estimated outlays		480	819	1,779	2,348	2,475
Estimated revenues		70	166	54	54	.....
Net budget impact: estimated net increase or decrease (—) in the deficit		410	653	1,725	2,294	2,475

¹ Less than \$500,000.

The Committee on Agriculture reported two amendments to H.R. 3810, neither of which is estimated by CBO to affect spending significantly.

The System for Alien Verification of Eligibility (SAVE), which would require a number of federal benefit programs to check with the Immigration and Naturalization Service as to the resident status of aliens applying for program benefits, was amended. These amendments would permit a program or jurisdiction not to use SAVE if waivers were granted by Department Secretaries. Waivers could be given if alternative verification systems were found to be as effective or if the administrative costs of SAVE exceeded any estimated savings. Without knowing more about SAVE and the extent to which waivers might be granted, the CBO estimate assumed that savings and costs would be approximately offsetting. If the cost effectiveness of SAVE could be measured accurately and waivers granted accordingly, however, these amendments would be likely to result in federal budgetary savings.

In addition, an amendment to Title I would prohibit officers or employees of the Immigration and Naturalization Service from entering the premises of a farm or other outdoor agricultural operation without the consent of the owner or without a properly executed warrant. This amendment is not expected to have a significant budgetary impact.

If you wish further details on this estimate, please call me or have your staff contact Janice Peskin (226-2820).

With best wishes,
Sincerely,

RUDOLPH G. PENNER, *Director*.

INFLATIONARY IMPACT STATEMENT

Pursuant to clauses 2(1)(4) of Rule XI of the Rules of the House of Representatives, the Committee estimates that enactment of H.R. 3810, as amended by the Committee, will have no inflationary impact on the national economy.

OVERSIGHT STATEMENT

No summary of oversight findings and recommendations made by the Committee on Government Operations under clause 2(b)(2) of Rule X of the Rules of the House of Representatives was available to the Committee with reference to the subject matter specifically addressed by H.R. 3810, as amended by the Committee on Agriculture.

No specific oversight activities other than the hearings detailed in this report were conducted by the Committee within the definition of clause 2(b)(1) of Rule X of the Rules of the House of Representatives.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, except as shown below, are shown in part 1 of this report, filed by the Committee on the Judiciary on July 16, 1986. The difference between the bill as reported by the Committee and as reported by the Committee on Judiciary are shown below using the following typographical devices (with "Judiciary" referring to the Committee on the Judiciary and "Agriculture" referring to the Committee on Agriculture):

Existing law in which no change is proposed by Judiciary or Agriculture, printed in roman.

New matter proposed to be inserted only by Agriculture (and not by Judiciary), printed in **boldface roman**.

IMMIGRATION AND NATIONALITY ACT

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TITLE II—IMMIGRATION

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CHAPTER 9 MISCELLANEOUS

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POWERS OF IMMIGRATION OFFICES AND EMPLOYEES

SEC. 287. (a) Any officer or employee of the Service authorized under regulations prescribed by the Attorney General shall have power without warrant—

(1) to interrogate any alien or person believed to be an alien as to his right to be or to remain in the United States;

(2) to arrest any alien who in his presence or view is entering or attempting to enter the United States in violation of any law or regulation made in pursuance of law regulating the admission, exclusion, or expulsion of aliens, or to arrest any alien in the United States, if he has reason to believe that the alien so arrested is in the United States in violation of any such law or regulation and is likely to escape before a warrant can be obtained for his arrest, but the alien arrested shall be taken without unnecessary delay for examination before an officer of the Service having authority to examine aliens as to their right to enter or remain in the United States;

(3) within a reasonable distance from any external boundary of the United States, to board and search for aliens any vessel within the territorial waters of the United States and any railway car, aircraft, conveyance, or vehicle, and within a distance of twenty-five miles from any such external boundary to have access to private lands, but not dwellings for the purpose of pa-

trolling the border to prevent the illegal entry of aliens into the United States; and

(4) to make arrests for felonies which have been committed and which are cognizable under any law of the United States regulating the admission, exclusion, or expulsion of aliens, if he has reason to believe that the person so arrested is guilty of such felony and if there is likelihood of the person escaping before a warrant can be obtained for his arrest, but the person arrested shall be taken without unnecessary delay before the nearest available officer empowered to commit persons charged with offenses against the laws of the United States. Any such employee shall also have the power to execute any warrant or other process issued by an officer under any law regulating the admission, exclusion, or expulsion of aliens.

(b) Any officer or employee of the Service designated by the Attorney General, whether individually or as one of a class, shall have power and authority to administer oaths and to take and consider evidence concerning the privilege of any person to enter, re-enter, pass through, or reside in the United States, or concerning any matter which is material or relevant to the enforcement of this Act and the administration of the Service; and any person to whom such oath has been administered (or who has executed an unsworn declaration, certificate, verification, or statement under penalty of perjury as permitted under section 1746 of title 28 United States Code), under the provisions of this Act, who shall knowingly or willfully give false evidence or swear (or subscribe under penalty of perjury as permitted under section 1746 of title 28, United States Code) to any false statement concerning any matter referred to in this subsection shall be guilty of perjury and shall be punished as provided by section 1621, title 18, United States Code.

(c) Any officer or employee of the Service authorized and designated under regulations prescribed by the Attorney General, whether individually or as one of a class, shall have power to conduct a search, without warrant, of the person, and of the personal effects in the possession of any person seeking admission to the United States, concerning whom such officer or employee may have reasonable cause to suspect that grounds exist for exclusion from the United States under this Act which would be disclosed by such search.

(d) Notwithstanding any other provision of this section other than paragraph (3) of subsection (a), an officer or employee of the Service may not enter without the consent of the owner (or agent thereof) or a properly executed warrant onto the premises of a farm or other outdoor agricultural operation for the purpose of interrogating a person believed to be an alien as to the person's right to be or to remain in the United States.

* * * * *

99TH CONGRESS
1st Session

SENATE

REPORT
99-132

IMMIGRATION REFORM AND CONTROL
ACT OF 1985

R E P O R T

together with

MINORITY VIEWS

OF THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ON

S. 1200, as amended



AUGUST 28, 1985.—Ordered to be printed

Filed under authority of the order of the Senate of August 1 (legislative
day, July 16), 1985

The user of the system will then sign under penalty of perjury a statement that the required documents have been examined, and obtain the signature of the prospective employee on a written statement that he is a U.S. citizen, permanent resident alien, or alien authorized to perform the particular work. In many cases existing application forms or something very similar could be used. In addition, the employer will be responsible for retaining these signed forms for 3 years or until 1 year after the employment ends, whichever is later. The Committee emphasizes that the user of the system will not be responsible for the genuineness of the documents, only that such documents reasonably appear on their face to be genuine.

The bill requires the executive branch to monitor and evaluate the verification system in order to make it more secure against fraudulent use. To the extent that existing documents are found not to be secure, the President is directed to implement such changes as are necessary to make the system secure in determining employment eligibility. For example, if an improved system were based on a card or other document or on a verifying telephone call to a government office, it would have to be resistant to use by imposters. If the system were to utilize a card or other document, such document would have to be resistant to counterfeiting and tampering. In an improved system, any underlying nonsecure documents, such as current forms of the birth certificate, would be examined by immigration experts. Users would utilize only the more secure system based upon them.

The President is required to give notice to Congress before implementing an improved system. If a minor change is involved (such as improvements in the current Social Security card), 60 days' notice is required. If a major change is involved (such as the creation of a new card or a telephone verification system), 2 years' notice is required, and funds must be specifically provided by Congress before the change is implemented. The President is authorized to undertake demonstration projects consistent with the statutory requirements for any new system. The project may not, however, last longer than 3 years.

Use of the verification system will not be mandatory. However, any employer who uses the system for all applicants will have an affirmative defense against the penalties. Furthermore, if an employer of four or more employees does not use the system, and an illegal alien is found in his employ, the employer will be presumed to have knowingly hired the alien. Such employer could rebut this presumption by "clear and convincing evidence."

It has been claimed that a new verification system would be too costly and that it would pose a threat to privacy and civil liberties.

On the cost issue the Committee believes that several points should be made. First, there are also tremendous costs in inadequate enforcement. The Congressional Budget Office has estimated that each unemployed person in the United States receives an average of about \$7,000 per year in unemployment and welfare benefits. If the number of illegal aliens in the United States today is estimated at 6 million and if even 1 percent hold jobs which unemployed Americans would take, then the savings would be \$420 million per year; if the displacement is 2 percent, the figure would

1, 1988 and end on September 30, 1989, in accordance with the 12-month application period specified in the bill. As a result, outlays would not begin until fiscal year 1989.

Third, this estimate depends importantly on the number of unauthorized aliens in the United States, for which little hard evidence exists. It has been generally accepted that there were 3 to 6 million unauthorized aliens in the United States in the late 1970s. The CBO estimate uses 4.5 million aliens in 1977, the midpoint of the range. Even less is known about how the numbers of unauthorized aliens in the United States may have changed in recent years, although anecdotal evidence indicates there has been some net inflow. Based on conversations with persons knowledgeable about the unauthorized alien population, CBO assumes a net increase of 150,000 in each year beginning in 1980. By 1986, then, CBO assumes that there will be 5.6 million unauthorized aliens in the United States.

Of the 5.6 million unauthorized aliens, CBO estimates that 17 percent have resided continuously in the United States since January 1, 1980, making them eligible for legalization under this bill. This figure is based on percentages from Immigration and Naturalization Service (INS) studies, which have been adjusted upward to reflect the assumption that some unauthorized aliens are aware of the possibility of legalization because of legislative activity in recent years. Among those eligible, we assume—again based on conversations with experts—that approximately 60 percent would apply for and be granted resident status. The resulting number of unauthorized aliens who would be granted resident status is estimated to be 565,000.

Finally, the number of legalized aliens who would qualify for government assistance programs is uncertain. In large part, this reflects a lack of data on the economic and demographic characteristics of unauthorized aliens—for example, their employment status and wages or their age and marital status. In developing the estimates of numbers of legalized aliens who would receive benefits from government programs, CBO assumes that the unauthorized aliens would have to show at the time of their application for residency that they had not been nor would they be likely to be “public charges,” as specified in section 212 of the Immigration and Nationality Act. Thus, at the time the aliens would become residents, they would presumably be working. Over time, however, they could be expected to resemble the U.S. population as to receipt of benefits from entitlement programs. By 1992, CBO assumes that the percentage of unauthorized aliens receiving government benefits would resemble that of the U.S. population for similar age, sex, ethnic origin, and income groupings. In the interim years, CBO assumes that a growing fraction would in fact receive benefits: 5 percent in 1989, 30 percent in 1990, and 75 percent in 1991.

In addition to the general basis of these estimates, each individual program estimate entailed specific procedures and assumptions. The details for each program are discussed below.

The Unemployment Compensation program provides weekly cash benefits to workers who are involuntarily unemployed and who have had at least a moderate amount of work experience during a 1-year period prior to losing their jobs. Under this bill, Unemploy-

ment Compensation costs for newly legalized alien workers are estimated to rise from an insignificant amount in 1989 to \$15 million in 1990. This estimate is based on several assumptions for newly legalized alien workers. Consistent with recent labor force data on young Hispanics, CBO assumes that 80 percent of these workers would participate in the labor force, a higher rate than the average of the U.S. population. Because most probably work in service industries, which are less prone to cyclical unemployment, and because even low-wage jobs in this country probably appear attractive when compared to those in the country of origin, CBO assumes that the newly-legalized population would have unemployment rates one percentage point lower than those in effect for the rest of the U.S. population. Further, assuming, as some evidence indicates, that these individuals' earnings are about 60 percent of those of comparable U.S. production or nonsupervisory workers (and assuming a 50 percent wage replacement rate), CBO estimates that the average weekly benefit amount for these workers would be about \$105 in 1989, one-fourth lower than that for the remainder of the population.

The Disability Insurance (DI) program covers persons who are totally disabled (whose disability is expected to last at least 12 months or result in death) and who have sufficient work histories in covered employment. Costs in DI of the legalized aliens are estimated to rise from an insignificant amount in 1989 to \$10 million in 1990. Because the evidence indicates that unauthorized aliens are relatively young on average, they would be less likely to be disabled than the U.S. population as a whole. Also, because they have been in the United States for relatively short periods of time, they might not qualify for DI, which requires for most workers covered earnings during 20 out of the last 40 calendar quarters. For all of these reasons, their DI reciprocity rate would be less than that of the U.S. population; CBO estimates the rate to be about 0.1 percent in 1989, with this rate rising to about 0.4 percent in 1990. Their benefit levels would also be less, reflecting lower than average wages and shorter work histories. The CBO estimates average benefits to be about \$4,365 in 1990 for aliens who entered before 1980.

Costs in the Medicare program, which provides health care coverage to the aged and disabled covered by Social Security, would rise slightly beginning in 1989, but would not exceed \$5 million through 1990. These costs would be for those aliens who would receive DI.

Grants to States, which would not begin until 1989 (the year the application process is assumed to end), are estimated to cost \$80 million in 1989 and \$140 million in 1990. Of this total, \$10 million in 1989 and \$70 million in 1990 would be for public assistance costs—cash and medical—and \$70 million in each year would be for costs of imprisoning unauthorized aliens.

Grants for public assistance are based on costs in State and local General Assistance (GA) programs. These programs are fully-funded by States and localities and provide benefits to low-income persons and families who do not qualify for the federally-funded cash welfare programs. GA provides both cash payments and medical coverage. Two groups of aliens would qualify for GA: those who would never be eligible for Federal welfare programs (for example,

low-income working two-parent families with children, and non-aged, non-disabled couples or single persons without children) and those who would be made ineligible for AFDC or SSI by the bill for a period of 6 years.

Among the first group, CBO estimates that 1.3 percent of the aliens would receive an average annual cash GA benefit of \$1,850 in 1989. This estimate is based on current reciprocity rates and benefit levels in GA programs. Among the second group, CBO's estimate for families who would have qualified for AFDC is based on the assumption that 52 percent of the aliens given permanent resident status would be married men and women, reflecting demographic data on unauthorized aliens, which show about 79 percent to be adults and the majority to be young and male, and marital rates in the United States. Of the married men and women, 4.5 percent of those not of Spanish origin and 17.0 percent of those of Spanish origin are estimated to receive AFDC. These rates of AFDC reciprocity are those which currently exist in the program. The average annual cash benefit for these alien families is estimated to be \$2,300 in 1989. The CBO estimate for aliens who would have qualified for SSI is based on a reciprocity rate of 0.90 percent of the alien population for the aged and 0.94 percent for the blind and disabled. The reciprocity rate for the aged is based on Census data which show 1.80 percent of illegal aliens to be aged, and assumed income eligibility of 100 percent, and a participation rate for the eligible of 50 percent. The reciprocity rate for the blind and disabled is based on the current reciprocity rate for the U.S. population. Their average annual cash benefit is estimated to be \$1,850 in 1989.

These aliens would also receive medical GA. Their average annual medical benefits are estimated to be \$940 in 1989.

Grants for imprisonment costs are based on an estimated 5,000 unauthorized aliens in State prisons. The prison costs per alien are estimated to be \$14,000 annually.

Revenues. The bill would require the Attorney General to collect a fee of at least \$100 for each application submitted by an alien for permanent or temporary residency under the legalization provisions in title II. The funds received from these application fees would be deposited into a separate account to be made available to cover only administrative expenses incurred in connection with the review of applications filed under this section. CBO estimates that approximately 700,000 aliens would apply for legal temporary residency in fiscal year 1989. Assuming a fee of \$100 per application, the lower limit specified in the bill, CBO estimates that the Government would receive approximately \$70 million in fiscal year 1989 from legalization application fees. Applications for permanent residency resulting in additional fees would occur beyond the estimating period in fiscal years 1991 and 1992. More money could be collected as a result of this provision if the Attorney General imposed a fee of more than \$100 per application.

In addition, the bill allows the Attorney General to impose a fee on employers participating in the agricultural labor transition program to recover reasonable costs of processing registrations. If this fee were imposed, it would increase revenues by \$10 million to \$20 million in fiscal years 1987 and 1988. The bill also allows the Secre-

tary of Labor to imposed a fee on employers importing temporary agricultural workers to recover the costs of processing applications for certification. It has not yet been determined whether the Secretary of Labor would impose such a fee and CBO is unable at this time to estimate how much money would be collected as a result of this fee.

Part B of title I increases penalties for immigration-related violations and part C outlines employer penalties for illegal employment of unauthorized aliens. No estimate can be made of the fines that would be collected by the Federal Government as a result of these sections.

In addition to the above effects on Federal revenues, there are potential effects on individual income tax revenues and social insurance contributions. Revenues would increase if some of the aliens who are not having taxes withheld from their wages at present were to have taxes withheld as a result of this legislation. Revenues would decrease if aliens who currently have taxes withheld and are entitled to refunds that they do not claim would claim refunds as a result of this bill. Given the uncertainties concerning characteristics of illegal aliens, and rough estimates showing the two effects above to be approximately offsetting, CBO shows no effect of the bill on these revenue sources.

6. Estimated cost to State and local governments: By legalizing certain unauthorized aliens currently residing in the United States, this bill could have sizable effects on State and local government budgets. Unauthorized aliens are not eligible for welfare programs that are partially- or fully-funded by States and localities. When legalized, these aliens would be eligible for such programs—immediately in the case of State programs and after 6 years in the case of programs financed by Federal and State governments jointly. Based on the CBO estimates, there would be no measurable effect on State and local budgets until 1989, when legalization would begin. In 1989 through 1992, States are estimated to save \$70 million a year; the grants to States authorized by the bill are estimated to cover all of the States' additional public assistance costs, as well as their existing costs—\$70 million a year—for imprisonment of illegal aliens. Beyond 1992, when the grants would no longer be available, States and localities would have higher expenditures in their public assistance programs, particularly until 1995 when the aliens would first become eligible for Federal programs based on financial need; CBO estimates these increased expenditures to be \$225 million to \$250 million a year.

A number of factors make these estimates uncertain. For purposes of this estimate, it is assumed that funds for the grants to States would be appropriated in full, or at least at a level that would cover fully State and local public assistance costs generated by the bill. If less than this amount were appropriated, States and localities would be faced with higher expenditures. Also, States and localities might have added costs if the public assistance expenditures generated by the bill were more than the \$600 million limit on grants; this appears unlikely, but given the uncertainty surrounding the estimates, it is still a possibility. On the other hand, with a full appropriation, savings to States and localities would be higher than CBO has estimated. Certain current expenditures by

States and localities would be covered under the grant: free health care provided to unauthorized aliens in public hospitals, assistance to Cuban and Haitian entrants, and any public assistance being received illegally by unauthorized aliens. However, CBO does not have sufficient information to estimate these potential savings.

In addition, other titles of the bill could affect State and local budgets. If the provisions of the bill that provide for employer sanctions and other means of reducing the flow of unauthorized aliens into the United States are effective, there would be some associated savings to State and local governments. For example, there would be fewer alien children to educate. The CBO cost estimate does not include such savings, given the uncertainties concerning flows of unauthorized aliens into the United States and the potential effectiveness of the bill's sanction provisions. It is also unknown to what extent State and local government budgets might be affected by any involvement of States and localities in the legalization application process, as provided for in title II.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Janice Peskin, Debra Goldberg, Neil Fisher, Paul Cullinan, Richard Hendrix, and Anne Manley.

10. Estimate approved by: C. G. Nuckols (for James L. Blum, Assistant Director for Budget Analysis).

VII. REGULATORY IMPACT EVALUATION

In compliance with subsection (b) of paragraph 11 of rule XXVI of the Standing Rules of the Senate, it is hereby stated that the only significant regulatory impacts that will result from the enactment of S. 1200 arise from certain requirements of sec. 101(a) of the bill, namely certain mandatory procedures for the verification of employment eligibility and recordkeeping in connection therewith. The impact of these requirements is discussed in the first section of part D of the General Statement, and in the portion of the Section-by-Section Analysis which describes sec. 101(a) of the bill. Any further discussion of such impacts would be impracticable, and, therefore, is omitted in accordance with clause (2) of such subsection (b), since details of the required forms and procedures will be developed only after enactment, by regulations of the Department of Justice and other executive agencies.

VIII. CHANGES IN EXISTING LAW

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing laws proposed to be made by S. 1200 are shown as follows: Existing law to be omitted is enclosed in black brackets, new matter is printed in *italic*, and existing law in which no change is proposed is shown in roman.

UNITED STATES CODE ANNOTATED

* * * * *

under this section and who are not otherwise deportable, to remain in the United States for brief periods in which to seek and accept employment with employers who are authorized to employ the workers.

(g) MISCELLANEOUS PROVISIONS.—

(1) AUTHORITY OF SECRETARY OF LABOR.—The Secretary of Labor is authorized to take such actions, including imposing appropriate penalties and seeking appropriate injunctive relief and specific performance of contractual obligations, as may be necessary to assure employer compliance with terms and conditions of employment under this section.

(2) APPROPRIATE DOCUMENTATION.—The Attorney General shall provide for such endorsement of entry and exit documents of temporary agricultural workers as may be necessary to carry out this section and to provide notice for purposes of section 274A.

(3) PREEMPTION.—The provisions of subsections (a) and (c) of section 214 and the provisions of this section preempt any State or local law regulating admissibility of nonimmigrant workers.

(4) TREATMENT FOR FICA, FUTA, AND SOCIAL SECURITY.—For the administration of the Federal Insurance Contributions Act, the Federal Unemployment Tax Act, and the Social Security Act, a temporary agricultural worker shall be considered to be an alien admitted to the United States to perform agricultural labor pursuant to sections 214(c) and 101(a)(15)(H)(ii) of this Act.

(h) DEFINITIONS.—For purposes of this section:

(1) AGRICULTURAL SERVICES.—The term “agricultural services” has the meaning given such term by the Secretary of Labor in regulations and includes—

(A) agricultural labor, defined in section 3121(g) of the Internal Revenue Code of 1954, and

(B) agriculture, as defined in section 3(f) of the Fair Labor Standards Act of 1938.

(2) ELIGIBLE INDIVIDUAL.—The term “eligible individual” means, with respect to employment, an individual who is not an unauthorized alien (as defined in section 274A(h)(2)) with respect to that employment.

(3) TEMPORARY AGRICULTURAL WORKER.—The term “temporary agricultural worker” means a nonimmigrant described in section 101(a)(15)(N).

VISA WAIVER PILOT PROGRAM FOR CERTAIN VISITORS

SEC. 217. (a) ESTABLISHMENT OF PILOT PROGRAM.—The Attorney General and the Secretary of State are authorized to establish a pilot program (hereafter in this section referred to as the “pilot program”) under which the requirement of paragraph (26)(B) of section 212(a) may be waived by the Attorney General and the Secretary of State, acting jointly and in accordance with this section, in the case of an alien who meets the following requirements:

(1) SEEKING ENTRY AS TOURIST FOR 90 DAYS OR LESS.—The alien is applying for admission during the pilot program period (as defined in subsection (e)) as a nonimmigrant visitor (de-

IMMIGRATION REFORM AND CONTROL ACT OF 1986

OCTOBER 14, 1986.—Ordered to be printed

Mr. RODINO, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany S. 1200]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 1200) to amend the Immigration and Nationality Act to effectively control unauthorized immigration to the United States, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment to the text of the House and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment to the text insert the following:

SECTION 1. SHORT TITLE; REFERENCES IN ACT.

(a) *SHORT TITLE.*—*This Act may be cited as the "Immigration Reform and Control Act of 1986".*

(b) *AMENDMENTS TO IMMIGRATION AND NATIONALITY ACT.*—*Except as otherwise specifically provided in this Act, whenever in this Act an amendment or repeal is expressed as an amendment to, or repeal of, a provision, the reference shall be deemed to be made to the Immigration and Nationality Act.*

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TITLE I—CONTROL OF ILLEGAL IMMIGRATION

PART A—EMPLOYMENT

Sec. 101. Control of unlawful employment of aliens.

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Sec. 103. Fraud and misuse of certain immigration-related documents.

PART B—IMPROVEMENT OF ENFORCEMENT AND SERVICES

- Sec. 111. Authorization of appropriations for enforcement and service activities of the Immigration and Naturalization Service.*
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TITLE IV—REPORTS TO CONGRESS

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- Sec. 701. Expeditious deportation of convicted aliens.*
- Sec. 702. Identification of facilities to incarcerate deportable or excludable aliens.*

SEC. 702. IDENTIFICATION OF FACILITIES TO INCARCERATE DEPORTABLE OR EXCLUDABLE ALIENS.

The President shall require the Secretary of Defense, in cooperation with the Attorney General and by not later than 60 days after the date of the enactment of this Act, to provide to the Attorney General a list of facilities of the Department of Defense that could be made available to the Bureau of Prisons for use in incarcerating aliens who are subject to exclusion or deportation from the United States.

And the House agree to the same.

That the Senate recede from its disagreement to the amendment to the title of the House and agree to the same.

From the Committee on the Judiciary:

For consideration of the entire Senate bill and House amendments:

PETER W. RODINO, Jr.,
ROBERT W. KASTENMEIER,
JOHN F. SEIBERLING,
ROMANO L. MAZZOLI,
MIKE SYNAR,
BARNEY FRANK,
CHARLES E. SCHUMER,
LAWRENCE J. SMITH,
HOWARD L. BERMAN,
RICK BOUCHER,
JOHN BRYANT,
HAMILTON FISH, Jr.,
CARLOS J. MOORHEAD,
DANIEL E. LUNGREN,
BILL MCCOLLUM,
E. CLAY SHAW, Jr.,
MIKE DEWINE,

From the Committee on Agriculture:

Solely for consideration of sections 121-125, 202(h), 203, and 304 of the Senate bill and sections 116, 121, 204, 301-305, and 701 of the House amendments:

LEON E. PANETTA,
JERRY HUCKABY,
SID MORRISON,

From the Committee on Education and Labor:

Solely for consideration of sections 101(d), 121-125, 202(h), 203, 304, 402, and 604 of the Senate bill and sections 101, 121, 201(h), 204, 301-305, 316(d), 402, 403, and 701 of the House amendments:

WILLIAM D. FORD,
JAMES M. JEFFORDS,

From the Committee on Energy and Commerce:

Solely for consideration of sections 125(b), 202(h), 203, 304, and 404 of the Senate bill and sections 121, 201(d), 201(h), 204, 404, and that portion of section 302(a) inserting subsection 210(f) in the Immigration and Nationality Act:

JOHN D. DINGELL,
HENRY A. WAXMAN,
WILLIAM E. DANNEMEYER,

From the Committee on Ways and Means:

Solely for consideration of sections 121(a), 121(g), 121(h), 124(c), 125(b), 202(h), 203, 304, 404, and 602 of the Senate bill and sections 121, 201(h), 204, 302(b), 402, 404, 601, 701, and that portion of section 302(a) inserting subsection 210(f) in the Immigration and Nationality Act:

HAROLD FORD,
DONALD J. PEASE,

From the Committee on Rules:

Solely for consideration of section 604(b) of the Senate bill and section 811 of the House amendments and modifications committed to Conference:

ANTHONY C. BEILENSON,
GENE TAYLOR,

Managers on the Part of the House.

STROM THURMOND,
AL SIMPSON,
JEREMIAH DENTON,
CHARLES MCC. MATHIAS, Jr.,
EDWARD M. KENNEDY,
PAUL SIMON,
HOWARD M. METZENBAUM,

Managers on the Part of the Senate.

respond to the fears and concerns expressed by many that sanctions will result in employment discrimination based on national origins or citizenship status. Thus, the anti-discrimination provision does not in itself in any way set a precedent for the expansion of other Title VII protections. Furthermore, nothing in this bill shall prevent the use of language as a Bona Fide Occupational Qualification.

VERIFICATION/RECORD KEEPING REQUIREMENTS

The Senate bill provide that employers with four or more employees, but not recruiters or referrers, must comply with various verification requirements. It required that a person employing four or more persons must verify that he/she has examined documents which establish both (1) employment authorization and (2) identity (showing that the individual is not presenting documents relating to another individual). A U.S. passport, certificate of U.S. citizenship, certificate of naturalization, or certain resident alien cards would establish both. Otherwise, one document of each type would be presented. Employment authorization documents would include the Social Security card or birth certificate. Identity documents would include: drivers's license, other State-issue card, or, under certain circumstances, other documentation approved by the Attorney General. The Senate bill also provided that the attestation forms signed by the employer and employees must be retained for specified periods.

The Senate bill did not impose civil fines for failure to satisfy the above requirements. Instead, it provided that if an employer did not meet them, the employer was presumed to have knowingly hired the alien. The presumption could have been rebutted by "clear and convincing evidence" to the contrary.

The House amendment required employers to verify all new hires by examining either (1) a U.S. passport, or (2) a U.S. birth certificate or Social Security card and a driver's license, state issued I.D. card, or an alien identification document and required each employer to attest, in writing, under penalty of perjury, that he/she has seen the documentation mentioned above. It also required the employee to attest in writing that he/she is authorized to work in the U.S. It also required the employer to retain the attestation forms for such periods as may be specified by the Attorney General. Failure to follow these verification/record keeping requirement would have subjected the offending party to a civil fine of between \$250-\$1000.

The House amendment also provided that nothing in this section of the legislation was to be construed as authorizing, directly or indirectly, the creation of a national identification card.

The Conference substitute adopts the House provisions on coverage for, and the mandatory nature of, the verification/record keeping requirements. It adopts the Senate provisions on the documents to be used during the verification process and the time periods for retaining the attestation forms. It provides a minimum civil fine of \$100 for violations of these requirements in lieu of the \$250 minimum fine in the House amendment. The Conference substitute also provides that violations of the hiring prohibition in the bill shall be

considered in assessing the level of the civil fine to be imposed. It also includes the House provision that "nothing in this section shall be construed to authorize, directly or indirectly, the issuance or use of national identification cards or the establishment of a national identification card."

VERIFICATION PROCESS AND STATE EMPLOYMENT SERVICE DOCUMENTATION

The House amendment provided that an employer will be deemed to have complied with the verification requirements, if an individual has been referred for employment by a state employment agency, if such employer retains appropriate documentation of the referral by that agency which specifically certifies that such agency has satisfied such requirements.

The Senate had no comparable provision.

The Conference substitute adopts the House provision. The Conferees, however, wish to emphasize that this provision is not intended to impose any affirmative duty or obligation upon State employment service offices or personnel.

TIME FOR COMPLIANCE WITH VERIFICATION PROCESS

The House amendment provided employers with a 24 hour grace period for compliance with the verification requirements.

The Senate bill had no comparable provision.

The Conference substitute does not contain the House provision. However, the Conferees direct the Attorney General to develop and promulgate regulations regarding the time for compliance which addresses the practical problems confronting farm workers and agricultural employers in satisfying the discrimination and verification requirements of this legislation. The employer shall be presumed to be in compliance with the paperwork and verification requirements for the first twenty-four hours after the worker has been hired to allow the worker time to produce the required documents under this subsection. The Justice Department may rebut this presumption with evidence that the employer has attempted to evade liability for employer sanctions and responsibilities for verification through the employment of day hires.

FUTURE VERIFICATION SYSTEM

A. GENERAL PROVISIONS

The Senate bill directed the President to monitor the verification system. If he finds that the system is not secure, he must seek to implement such changes as may be necessary to establish a secure system to determine employment authorization. Such changes would only be permitted after notice to Congress: 2 years for a major change, such as a telephone verification system or a new identification document, and 60 days for a non-Major change, such as an improved Social Security card. It also authorized the President to establish demonstration projects for up to three years, and required studies of the Executive Branch and GAO to evaluate the use of a telephone verification system and possible improvements in the current Social Security card.

The House amendment directed the Attorney General, in consultation with the Secretaries of Labor and Health and Human Services, to conduct a study on the use of a telephone verification system for determining the employment eligibility of aliens in the U.S. The House amendment also directed the Secretary of Health and Human Services to conduct a feasibility study of a social security number validation system.

The conference substitute adopts the Senate provision regarding a future verification system, with an amendment with regard to the use of Social Security cards (discussed below) and with the addition of House language prohibiting the development of a national i.d. card. The conference substitute also includes a study of both the telephone verification system and a study on the feasibility of a social security number validation system.

The scope of the studies required in sections 101(d) and 101(e) of the House amendment are separate and distinct and do not overlap. The study required by section 101(d) is to examine the possible use of the Federal data bases excluding data collected through the Social Security Administration by use of the social security number. The study conducted under section 101(e) is to be the only examination of the feasibility of a telephone verification system involving the social security number, account card, and data collected using the social security number and card.

B. USE OF SOCIAL SECURITY CARDS

The Senate bill allowed the use of current and previous government-issued social security cards as proof of employment authorization in the U.S., allowed the President to require (without notice to Congress) universal use of the current social security card for employment authorization, allowed the President to make changes in the current version of the social security card after 60 days notices to Congress, and allowed the President to require a new card, document, or other system to be presented for worker verification after two years' notice to Congress and specific Congressional appropriations for the change.

The House amendment allowed the use of current and previous government-issued social security cards as proof of employment authorization in the United States.

The conference substitute requires the President to provide one year's notice to Congress before instituting any change in the social security card (including a requirement that current social security cards be universally used for employment authorization), and requires Congress to specifically appropriate funds for any such change.

INS FUNDING FOR ENFORCEMENT AND SERVICES

The Senate bill provided a two-year authorization of appropriations for the Immigration and Naturalization Service as follows: \$840 million for fiscal year 1987 and \$830 million for fiscal year 1988.

The House amendment provided a two-year supplemental authorization of appropriations for the Immigration and Naturalization Service as follows: \$422 million for fiscal year 1986 and \$419

million for fiscal year 1987. The amendment also authorizes, for fiscal years 1987 through 1989, such sums as may be necessary to provide for an increase in border patrol personnel so that the average level of such personnel is 50% higher than such level in fiscal year 1986.

The Conference substitute provides supplemental authorizations at the House levels for fiscal years 1987 and 1988. Within these levels the conferees were aware that at least \$184 million was to be expended on enhanced enforcement efforts. The Conferees agree as to the need for sufficient funding to ensure a 50 percent increase in border patrol personnel in accordance with the House provision.

IMMIGRATION EMERGENCIES

The Senate bill established a revolving fund to provide assistance in the case of an immigration emergency.

The House amendment required the Attorney General to develop a contingency plan for operation in an immigration emergency and established a fund to be used for assistance.

The Conference substitute adopts the Senate provision but deletes the revolving nature of the emergency fund. The Conference substitute deletes the requirement that the Attorney General develop a contingency plan because it is the Conferees' understanding that a plan has already been developed.

SAVE PROGRAM

A. GENERAL REQUIREMENTS

The Senate bill required States to verify, through INS computer records, the legal status of all aliens applying for benefits under certain programs of public assistance.

The House amendment required States to verify, through INS computer records, the legal status of all aliens applying for benefits under certain programs of public assistance, and allowed a waiver to be granted, upon recommendation of the appropriate Secretary, for covered programs where a particular verification program would not be cost-effective or would be redundant.

The Conference substitute adopts the House provision.

B. PROGRAM INFRASTRUCTURE

The Senate bill reimbursed state governments for 90% of the non-labor costs of the SAVE program, and applied the verification requirements to the AFDC, Medicaid, Unemployment Compensation, Food Stamp, and SSI programs.

The House amendment reimbursed state governments for 100% of the total costs of the SAVE program, applied the verification requirements to the AFC, Medicaid, Unemployment Compensation, Food Stamp, Housing Assistance, and Higher Education programs, and provided for a hearing process in the case of an applicant with an unresolved immigration status.

The conference substitute adopts the House provision.

Finder's Aid
P.L. 99-643, (100 Stat. 3574), Approved November 10, 1986
Employment Opportunities for Disabled Americans Act

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-893</u>	<u>S.Rep. 99-466</u>
Supplemental Security Income--Eligibility During Initial 2 Months in Certain Institutions (technical amendment)	1611(e)(1)(A) (SSI)	3(a)(1)	3574	—	14
Supplemental Security Income--Eligibility During Initial 2 Months in Certain Institutions (technical amendment)	1611(e)(1)(B) (SSI) New	3(a)(2)	3574	—	14
Supplemental Security Income--Eligibility During Initial 2 Months in Certain Institutions	1611(e)(1)(E) (SSI) New	3(a)(3)	3574	3, 11	1, 4, 14
Supplemental Security Income--Eligibility During Initial 2 Months in Certain Institutions	1611(e)(1)(F) (SSI) New	3(a)(3)	3574	3, 11	1, 4, 14
Supplemental Security Income--Improvements in Program for Working Disabled Individuals (conforming amendment)	1611(e)(4) (SSI) Stricken	4(d)(1)	3577	4, 11	1, 5
Supplemental Security Income--Treatment of Certain Couples in Medical Institutions	1611(e)(5) (SSI) New	9(a)	3579	2, 8	—
Supplemental Security Income--Improvements in Programs for Working Disabled Individuals-- Application and Review	1611(i) (SSI) New	4(c)(3)	3577	4, 11	1, 5

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-893</u>	<u>S.Rep. 99-466</u>
Supplemental Security Income--Meaning of Terms--Substantial Gainful Activity-- Improvements in Program for Working Disabled (conforming amendment)	1614(a)(3)(D) (SSI)	4(d)(2)(A)	3577	4, 11	1, 5, 15
Supplemental Security Income--Meaning of Terms--Substantial Gainful Activity-- Improvements in Program for Working Disabled (conforming amendment)	1614(a)(3)(F) (SSI) Stricken	4(d)(2)(B)	3577	4, 11	1, 5, 15
Supplemental Security Income--Meaning of Terms--Substantial Gainful Activity-- Improvements in Program for Working Disabled (technical amendment)	1614(a)(3)(G) (SSI) Redesignated as (F)	4(d)(2)(B)	3577	--	16
Supplemental Security Income--Meaning of Terms--Substantial Gainful Activity-- Improvements in Program for Working Disabled (technical amendment)	1614(a)(3)(H) (SSI) Redesignated as (G)	4(d)(2)(B)	3577	--	16
Supplemental Security Income--Meaning of Terms--Services in Trial Work Period-- Improvements in Program for Working Disabled (conforming amendment)	1614(a)(4) (SSI) Stricken	4(d)(3)(A)	3577	4, 11	1, 5, 16
Supplemental Security Income--Meaning of Terms--Services in Trial Work Period-- Improvements in Program for Working Disabled (technical amendment)	1614(a)(5) (SSI) Redesignated as (4)	4(d)(3)(A)	3577	--	16
Supplemental Security Income--Improvements in Program for Working Disabled--Cash Benefits	1619(a) (SSI)	4(a)	3575	4, 11	1, 5, 17

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-893</u>	<u>S.Rep. 99-466</u>
Supplemental Security Income--Improvements in Program for Working Disabled--Application and Review Requirements (conforming amendment)	1619(a) (SSI)	4(c)(2)(A)	3577	4, 11	1, 5, 17
Supplemental Security Income--Improvements in Program for Working Disabled--Continuing Benefits Under Title XIX (conforming amendment)	1619(b)(1) (SSI)	4(b)(1)	3575	5, 17	2, 10, 18
Supplemental Security Income--Improvements in Program for Working Disabled--Continuing Benefits Under Title XIX (conforming amendment)	1619(b)(4) (SSI)	4(b)(2)	3575	5, 17	2, 10, 18
Supplemental Security Income--Improvements in Program for Working Disabled--Continuing Benefits Under Title XIX (technical amendment)	1619(b)(1) (SSI) Redesignated as (A)	4(b)(3)	3575	--	18
Supplemental Security Income--Improvements in Program for Working Disabled--Continuing Benefits Under Title XIX (technical amendment)	1619(b)(2) (SSI) Redesignated as (B)	4(b)(3)	3575	--	18
Supplemental Security Income--Improvements in Program for Working Disabled--Continuing Benefits Under Title XIX (technical amendment)	1619(b)(3) (SSI) Redesignated as (C)	4(b)(3)	3575	--	18
Supplemental Security Income--Improvements in Program for Working Disabled--Continuing Benefits Under Title XIX (technical amendment)	1619(b)(4) (SSI) Redesignated as (D)	4(b)(3)	3575	--	18

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-893</u>	<u>S.Rep. 99-466</u>
Supplemental Security Income--Improvements in Program for Working Disabled--Continuing Benefits Under Title XIX	1619(b)(1) (SSI)	4(b)(4)	3576	5, 17	2, 10, 18
Supplemental Security Income--Improvements in Program for Working Disabled--Applications and Review Requirements (conforming amendment)	1619(b) (SSI)	4(c)(2)(B)	3577	4, 11	1, 5, 18
Supplemental Security Income--Improvements in Program for Working Disabled--Continuing Benefits Under Title XIX--Earnings Determinations	1619(b)(2) (SSI) New	4(b)(5)	3576	5, 17	2, 10, 18
Supplemental Security Income--Medicaid Eligibility of the Working Disabled	1619(b)(3) (SSI) New	7(a)	3579	5, 17	2, 10, 18
Supplemental Security Income--Overpayments and Underpayments-- Deceased Recipients (technical amendment)	1631(b)(1)(A) (SSI)	8(a)(1)	3579	--	--
Supplemental Security Income--Overpayments and Underpayments-- Deceased Recipients	1631(b)(1)(A) (SSI)	8(a)(2)	3579	4, 7	--
Supplemental Security Income--Overpayments and Underpayments-- Deceased Recipients (technical amendment)	1631(b)(1)(B) (SSI)	8(a)(3)	3579	--	--
Supplemental Security Income--Overpayments and Underpayments-- Deceased Recipients (technical amendment)	1631(b)(1)(B)(i) (SSI) Redesignated as (I)	8(a)(4)	3579	--	--

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-893</u>	<u>S.Rep. 99-466</u>
Supplemental Security Income--Overpayments and Underpayments-- Deceased Recipients (technical amendment)	1631(b)(1)(B)(ii) (SSI) Redesignated as (II)	8(a)(4)	3579	--	--
Supplemental Security Income--Overpayments and Underpayments-- Deceased Recipients (technical amendment)	1631(b)(1) (SSI)	8(a)(5)	3579	--	--
Supplemental Security Income--Improvements in Program for Working Disabled--Application and Review Requirements (technical amendment)	1631(e)(1)(A) (SSI)	4(c)(1)(A)	3576	--	19
Supplemental Security Income--Improvements in Program for Working Disabled--Application and Review Requirements	1631(j) (SSI) New	4(c)(1)(B)	3576	4, 11	1, 5, 19
Supplemental Security Income--Improvements in Program for Working Disabled--Application and Review Requirements (conforming amendment)	1631(j)(2)(A) (SSI)	4(d)(3)(B)	3577	4, 11	1, 5, 20
Supplemental Security Income--Program for Working Disabled-- Notifications to Applicants and Recipients	1631(k) (SSI) New	5	3578	4, 16	2, 9, 20
Supplemental Security Income Benefits--Loss of SSI Due to Receipt of Disabled Child's Benefits--Continued Medicaid Eligibility	1634(c) (SSI) New	6(a)	3578	5, 16, 20	2, 10, 20
Medicaid--Eligibility for Certain Recipients of Cash Benefits Under the Program for Working Disabled (conforming amendment)	1902(f)	7(b)	3579	5, 17	2, 10, 21

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-893</u>	<u>S.Rep. 99-466</u>
Medicaid--Disregard of Certain SSI Payments in Determining Past Eligibility Contribu- tions to Cost of Care	1902(9) New	3(b)	3575	--	21
Medicaid--Loss of SSI Due to Receipt of Disabled Child's Benefits--Continued Medicaid Eligibility (technical amendment)	1920(a)(2)(A)	6(c)(1)	3578	--	22
Medicaid--Loss of SSI Due to Receipt of Disabled Child's Benefits--Continued Medicaid Eligibility (conforming amendment)	1920(a)(2)(B) New	6(c)(2)	3578	5, 16, 20	2, 10, 22

PUBLIC LAW 99-643—NOV. 10, 1986

**EMPLOYMENT OPPORTUNITIES FOR
DISABLED AMERICANS ACT**

Public Law 99-643
99th Congress

An Act

Nov. 10, 1986
[H.R. 5595]

To make permanent and improve the provisions of section 1619 of the Social Security Act, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Employment Opportunities for Disabled Americans Act".

SEC. 2. PERMANENT AUTHORIZATION OF PROGRAM OF BENEFITS UNDER SECTION 1619.

Section 201(d) of the Social Security Disability Amendments of 1980 (42 U.S.C. 1382h note) is amended by striking out ", but shall remain in effect only through June 30, 1987".

SEC. 3. ELIGIBILITY OF CERTAIN DISABLED OR BLIND INDIVIDUALS FOR BENEFITS DURING INITIAL TWO MONTHS IN CERTAIN INSTITUTIONS.

(a) IN GENERAL.—Section 1611(e)(1) of the Social Security Act (42 U.S.C. 1382(e)(1)) is amended—

(1) in subparagraph (A) by striking out "and (D)" and inserting in lieu thereof "(D), and (E)";

(2) in subparagraph (B) by inserting "(subject to subparagraph (E))" after "shall be payable"; and

(3) by adding at the end thereof the following new subparagraphs:

"(E) Notwithstanding subparagraphs (A) and (B), any individual who—

"(i)(I) is an inmate of a public institution, the primary purpose of which is the provision of medical or psychiatric care, throughout any month as described in subparagraph (A), or

"(II) is in a hospital, extended care facility, nursing home, or intermediate care facility throughout any month as described in subparagraph (B),

"(ii) was eligible under section 1619 (a) or (b) for the month preceding such month, and

"(iii) under an agreement of the public institution or the hospital, extended care facility, nursing home, or intermediate care facility is permitted to retain any benefit payable by reason of this subparagraph,

may be an eligible individual or eligible spouse for purposes of this title (and entitled to a benefit determined on the basis of the rate applicable under subsection (b)) for the month referred to in subclause (I) or (II) of clause (i) and, if such subclause still applies, for the succeeding month.

"(F) An individual who is an eligible individual or an eligible spouse for a month by reason of subparagraph (E) shall not be

Employment
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for Disabled
Americans Act.
5 USC 1305
note.

treated as being eligible under section 1619 (a) or (b) for such month for purposes of clause (ii) of such subparagraph.” 42 USC 1382h.

(b) **MEDICAID STATE PLAN REQUIREMENT.**—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

“(l) Notwithstanding any provision of subsection (a) to the contrary, a State plan under this title shall provide that any supplemental security income benefits paid by reason of section 1611(e)(1)(E) to an individual who—

Ante, p. 3574.

“(1) is eligible for medical assistance under the plan, and

“(2) is in a hospital, skilled nursing facility, or intermediate care facility at the time such benefits are paid,

will be disregarded for purposes of determining the amount of any post-eligibility contribution by the individual to the cost of the care and services provided by the hospital, skilled nursing facility, or intermediate care facility.”.

SEC. 4. IMPROVEMENTS TO SECTION 1619 PROGRAM.

(a) **CASH BENEFITS.**—Section 1619(a) of the Social Security Act (42 U.S.C. 1382h(a)) is amended to read as follows:

“(a)(1) Any individual who was determined to be an eligible individual (or eligible spouse) by reason of being under a disability and was eligible to receive benefits under section 1611 (or a federally administered State supplementary payment) for a month and whose earnings in a subsequent month exceed the amount designated by the Secretary ordinarily to represent substantial gainful activity shall qualify for a monthly benefit under this subsection for such subsequent month (which shall be in lieu of any benefit under section 1611) equal to an amount determined under section 1611(b)(1) (or, in the case of an individual who has an eligible spouse, under section 1611(b)(2)), and for purposes of title XIX shall be considered to be receiving supplemental security income benefits under this title, for so long as—

State and local governments.

“(A) such individual continues to have the disabling physical or mental impairment on the basis of which such individual was found to be under a disability; and

“(B) the income of such individual, other than income excluded pursuant to section 1612(b), is not equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611 and such individual meets all other non-disability-related requirements for eligibility for benefits under this title.

42 USC 1396.

“(2) The Secretary shall make a determination under paragraph (1)(A) with respect to an individual not later than 12 months after the first month for which the individual qualifies for a benefit under this subsection.”.

42 USC 1382a.

(b) **CONTINUING BENEFITS UNDER TITLE XIX.**—Section 1619(b) of such Act is amended—

(1) in paragraph (1) by striking out “continues to meet” and inserting in lieu thereof “meets”,

(2) in paragraph (4) by striking out “benefits under this title and title XIX” and inserting in lieu thereof “benefits under this title (including any federally administered State supplementary payments), benefits under title XIX, and publicly funded attendant care services (including personal care assistance).”,

State and local governments.

(3) by redesignating paragraphs (1) through (4) as subparagraphs (A) through (D), respectively,

(4) by striking out the matter preceding subparagraph (A) (as redesignated by paragraph (3)) and inserting in lieu thereof the following:

Blind persons.
State and local
governments.
42 USC 1396.
Post, p. 3577.

“(b)(1) For purposes of title XIX, any individual under age 65 who was determined to be a blind or disabled individual eligible to receive a benefit under section 1611 or any federally administered State supplementary payment for a month and who in a subsequent month is ineligible for benefits under this title (and for any federally administered State supplementary payments) because of his or her income shall, nevertheless, be considered to be receiving supplemental security income benefits for such subsequent month provided that the Secretary determines under regulations that—”, and

(5) by adding at the end thereof (after and below subparagraph (D), as so redesignated) the following new paragraphs: “(2)(A) Determinations made under paragraph (1)(D) shall be based on information and data updated no less frequently than annually.

“(B) In determining an individual’s earnings for purposes of paragraph (1)(D), there shall be excluded from such earnings an amount equal to the sum of any amounts which are or would be excluded under clauses (ii) and (iv) of section 1612(b)(4)(B) (or under clauses (ii) and (iii) of section 1612(b)(4)(A)) in determining his or her income.”.

(c) REVIEW PROCESS FOR CERTAIN INDIVIDUALS.—

(1) Section 1631 of such Act (42 U.S.C. 1383) is amended—

(A) in subsection (e)(1)(A) by striking out “subparagraph (B)” and inserting in lieu thereof “subparagraph (B) and subsection (j)”, and

(B) by adding at the end thereof the following new subsection:

“Application and Review Requirements for Certain Individuals

“(j)(1) Notwithstanding any provision of section 1611 or 1619, any individual who—

“(A) was an eligible individual (or eligible spouse) under section 1611 or was eligible for benefits under or pursuant to section 1619, and

“(B) who, after such eligibility, is ineligible for benefits under or pursuant to both such sections for a period of 12 consecutive months,

may not thereafter become eligible for benefits under or pursuant to either such section until the individual has reapplied for benefits under section 1611 and been determined to be eligible for benefits under such section.

“(2)(A) Notwithstanding any provision of section 1611 or section 1619, any individual who was eligible for benefits pursuant to section 1619(b), and who—

“(i)(I) on the basis of the same impairment on which his or her eligibility under such section 1619(b) was based becomes eligible for benefits under section 1611 or 1619(a) for a month that follows a period during which the individual was ineligible for benefits under sections 1611 and 1619(a), and

“(II) has earned income (other than income excluded pursuant to section 1612(b)) for any month in the 12-month period preceding such month that is equal to or in excess of the amount that would cause him or her to be ineligible for payments under

42 USC 1382a.

42 USC 1382h.

section 1611(b) for that month (if he or she were otherwise eligible for such payments); or 42 USC 1382.

“(ii)(I) on the basis of the same impairment on which his or her eligibility under such section 1619(b) was based becomes eligible under section 1619(b) for a month that follows a period during which the individual was ineligible under section 1611 and section 1619, and 42 USC 1382h.

“(II) has earned income (other than income excluded pursuant to section 1612(b)) for such month or for any month in the 12-month period preceding such month that is equal to or in excess of the amount that would cause him or her to be ineligible for payments under section 1611(b) for that month (if he or she were otherwise eligible for such payments); 42 USC 1382a.

shall, upon becoming eligible (as described in clause (i)(I) or (ii)(I)), be subject to a prompt review of the type described in section 1614(a)(5). 42 USC 1382c.

“(B) If the Secretary determines pursuant to a review required by subparagraph (A) that the impairment upon which the eligibility of an individual is based has ceased, does not exist, or is not disabling, such individual may not thereafter become eligible for a benefit under or pursuant to section 1611 or section 1619 until the individual has reapplied for benefits under section 1611 and been determined to be eligible for benefits under such section.”.

(2) Section 1619 of such Act (as amended by subsections (a) and (b) of this section) is further amended—

(A) in subsection (a) by striking out “Any individual” and inserting in lieu thereof “Except as provided in section 1631(j), any individual”, and

(B) in subsection (b) by striking out “For purposes of” and inserting in lieu thereof “Except as provided in section 1631(j), for purposes of”. Ante, p. 3576.

(3) Section 1611 of such Act (42 U.S.C. 1382) is amended by adding at the end thereof the following new subsection:

“Application and Review Requirements for Certain Individuals

“(i) For application and review requirements affecting the eligibility of certain individuals, see section 1631(j).”.

(d) CONFORMING AMENDMENTS.—

(1) Section 1611(e) of such Act (42 U.S.C. 1382(e)) is amended by striking out paragraph (4).

(2) Section 1614(a)(3) of such Act (42 U.S.C. 1382c(a)(3)) is amended—

(A) in subparagraph (D) by striking out “, except for purposes of subparagraph (F) or paragraph (4),”, and

(B) by striking out subparagraph (F), and by redesignating subparagraphs (G) and (H) as subparagraphs (F) and (G), respectively.

(3)(A) Section 1614(a) of such Act (as amended by paragraph (2)) is further amended by striking out paragraph (4) and by redesignating paragraph (5) as paragraph (4).

(B) Section 1631(j)(2)(A) of such Act (as added by subsection (c)) is amended by striking out “section 1614(a)(5)” and inserting in lieu thereof “section 1614(a)(4)”.

SEC. 5. NOTIFICATIONS TO APPLICANTS AND RECIPIENTS.

Section 1631 of the Social Security Act (42 U.S.C. 1383) (as amended by section 4) is further amended by adding at the end thereof the following new subsection:

“Notifications to Applicants and Recipients

Blind persons.
Ante, p. 3577.
42 USC 1382h.

“(k) The Secretary shall notify an individual receiving benefits under section 1611 on the basis of disability or blindness of his or her potential eligibility for benefits under or pursuant to section 1619—

“(1) at the time of the initial award of benefits to the individual under section 1611 (if the individual has attained the age of 18 at the time of such initial award), and

“(2) at the earliest time after an initial award of benefits to an individual under section 1611 that the individual’s earned income for a month (other than income excluded pursuant to section 1612(b)) is \$200 or more, and periodically thereafter so long as such individual has earned income (other than income so excluded) of \$200 or more per month.”.

42 USC 1382a.

SEC. 6. LOSS OF SSI BENEFITS UPON ENTITLEMENT TO CHILD’S INSURANCE BENEFITS BASED ON DISABILITY.

(a) **IN GENERAL.**—Section 1634 of the Social Security Act (42 U.S.C. 1383c) is amended by adding at the end thereof the following new subsection:

Blind persons.

“(c) If any individual who has attained the age of 18 and is receiving benefits under this title on the basis of blindness or a disability which began before he or she attained the age of 22—

“(1) becomes entitled, on or after the effective date of this subsection, to child’s insurance benefits which are payable under section 202(d) on the basis of such disability or to an increase in the amount of the child’s insurance benefits which are so payable, and

“(2) ceases to be eligible for benefits under this title because of such child’s insurance benefits or because of the increase in such child’s insurance benefits,

42 USC 402.

42 USC 1396.

such individual shall be treated for purposes of title XIX as receiving benefits under this title so long as he or she would be eligible for benefits under this title in the absence of such child’s insurance benefits or such increase.”.

42 USC 1383e
note.
42 USC 1383c.
42 USC 1381.

(b) **STATE DETERMINATIONS.**—Any determination required under section 1634(c) of the Social Security Act with respect to whether an individual would be eligible for benefits under title XVI of such Act in the absence of children’s benefits (or an increase thereof) shall be made by the appropriate State agency.

(c) **CONFORMING CHANGE.**—Section 1920(a)(2) of such Act (42 U.S.C. 1396s(a)(2)) is amended—

(1) by inserting “(A)” before “Section”, and

(2) by adding after and below subparagraph (A) the following new subparagraph:

“(B) Section 1634 of this Act (relating to individuals who lose eligibility for SSI benefits due to entitlement to child’s insurance benefits under section 202(d) of this Act).”.

SEC. 7. MEDICAID ELIGIBILITY FOR CERTAIN RECIPIENTS OF CASH BENEFITS UNDER SECTION 1619.

(a) **IN GENERAL.**—Section 1619(b) of the Social Security Act (42 U.S.C. 1382h(b)) (as amended by section 4) is further amended by adding at the end thereof the following new paragraph:

“(3) In the case of a State that exercises the option under section 1902(f), any individual who—

State and local governments.
42 USC 1396a.

“(A)(i) qualifies for a benefit under subsection (a), or

“(ii) meets the requirements of paragraph (1); and

“(B) was eligible for medical assistance under the State plan approved under title XIX in the month immediately preceding the first month in which the individual qualified for a benefit under such subsection or met such requirements,

42 USC 1396.

shall remain eligible for medical assistance under such plan for so long as the individual qualifies for a benefit under such subsection or meets such requirements.”

(b) **CONFORMING AMENDMENT.**—Section 1902(f) of such Act (42 U.S.C. 1396a(f)) is amended by striking out “subsection (e)” and inserting in lieu thereof “subsection (e) and section 1619(b)(3)”.

42 USC 1382h.

SEC. 8. PAYMENT OF BENEFITS DUE DECEASED RECIPIENTS.

(a) **IN GENERAL.**—Section 1631(b)(1) of the Social Security Act is amended—

42 USC 1383.

(1) by inserting “(A)” after “(1)”;

(2) by striking out “by recovery from” where it first appears in the first sentence and all that follows down through “The Secretary (A) shall make” and inserting in lieu thereof the following:

“by recovery from such individual or his eligible spouse (or from the estate of either) or by payment to such individual or his eligible spouse, or, if such individual is deceased, by payment—

“(i) to any surviving spouse of such individual, whether or not the individual’s eligible spouse, if (within the meaning of the first sentence of section 202(i)) such surviving husband or wife was living in the same household with the individual at the time of his death or within the 6 months immediately preceding the month of such death, or

42 USC 402.

“(ii) if such individual was a disabled or blind child who was living with his parent or parents at the time of his death or within the 6 months immediately preceding the month of such death, to such parent or parents.

Children and youth.

“(B) The Secretary (i) shall make”;

(3) by striking out “and (B) shall in any event” and inserting in lieu thereof “and (ii) shall in any event”;

(4) by striking out “(i) the amount” and “(ii) an amount” and inserting in lieu thereof “(I) the amount” and “(II) an amount”, respectively; and

(5) by striking out “clause (B)” and “clause (A)” in the last sentence and inserting in lieu thereof “clause (ii)” and “clause (i)”, respectively.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply with respect to benefits payable for months after May 1986.

42 USC 1383 note.

SEC. 9. TREATMENT OF CERTAIN COUPLES IN MEDICAL INSTITUTIONS.

(a) **IN GENERAL.**—Section 1611(e) of the Social Security Act is amended by adding at the end thereof the following new subsection:

42 USC 1382.

State and local
governments.

“(5) Notwithstanding anything to the contrary in the criteria being used by the Secretary in determining when a husband and wife are to be considered two eligible individuals for purposes of this title and when they are to be considered an eligible individual with an eligible spouse, the State agency administering or supervising the administration of a State plan under any other program under this Act may (in the administration of such plan) treat a husband and wife sharing a room or comparable accommodation in a hospital, home, or facility described in paragraph (1)(B) as though they were an eligible individual with his or her eligible spouse for purposes of this title (rather than two eligible individuals), after they have continuously shared such a room or accommodation for 6 months, if treating such husband and wife as two eligible individuals would prevent either of them from receiving benefits or assistance under such plan or reduce the amount thereof.”

42 USC 1382
note.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 10. EFFECTIVE DATES.

42 USC 1382h
note.

(a) **PERMANENT AUTHORIZATION.**—The amendment made by section 2 shall become effective on the date of the enactment of this Act.

42 USC 1396a
note.

(b) **PROGRAM MODIFICATIONS.**—

(1) Except as provided in paragraph (2), the amendments made by sections 3, 4, 5, 6, and 7 shall become effective on July 1, 1987.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the requirements imposed by the amendments made by section 3(b) and section 7 of this Act, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such additional requirements until 60 days after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

State and local
governments.
42 USC 1396.

Approved November 10, 1986.

LEGISLATIVE HISTORY—H.R. 5595 (S. 2209):

HOUSE REPORTS: No. 99-893 (Comm. on Ways and Means).

SENATE REPORTS: No. 99-466 accompanying S. 2209 (Comm. on Finance).

CONGRESSIONAL RECORD, Vol. 32 (1986):

Sept. 30, considered and passed House.

Oct. 8, considered and passed Senate, amended, in lieu of S. 2209.

Oct. 15, House concurred in Senate amendments with an amendment.

Oct. 16, House agreed to certain Senate amendment, to another with amendments.

Oct. 18, Senate concurred in House amendments.

SSI IMPROVEMENT AMENDMENTS OF 1986

SEPTEMBER 25, 1986.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. ROSTENKOWSKI, from the Committee on Ways and Means,
submitted the following

REPORT

[To accompany H.R. 5595]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 5595) to amend title XVI of the Social Security Act to make necessary improvements in the SSI program with the objective of assuring that such program (including the work incentive provisions in section 1619 of such act) will more realistically and more equitably reflect the needs and circumstances of applicants and recipients thereunder, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

I. SUMMARY OF PROVISIONS

TITLE I—GENERAL SSI AMENDMENTS

Treatment of Income and Resources

1. Exclusion of certain temporary income in retrospective accounting (Section 101)

Section 101 requires that temporary non-recurring income received in the initial month of eligibility or re-eligibility by SSI recipients may not be counted more than once under the retrospective accounting process.

2. Exclusion of certain real and personal property from income (Section 102)

Section 102 provides for excluding from countable income certain unearned income received in the form of real or personal property,

e.g. gifts or inheritances, which would not be counted as a resource in the following month.

3. Modification of penalties where assets are transferred at less than fair market value (Section 103)

Section 103 would modify the provision in current law which provides a two year delay in eligibility for SSI benefits when resources are transferred at less than fair market value in order to qualify for benefits. The amendment would provide that there would be no effect on eligibility unless the amount of the total uncompensated value of the resources given as gifts or sold exceeded \$3,000. In addition, in cases where there would otherwise be a denial of benefits, the Secretary of HHS would have the authority to waive the denial to the extent necessary to avoid undue hardship.

Provisions Related to Eligibility

4. Payment of benefits on behalf of deceased recipients (Section 111)

Section 111 provides for payment of benefits on behalf of a deceased SSI recipient to the ineligible spouse and the parent of a disabled or blind child. Present law provides that only a spouse who is also eligible for SSI may receive the payment that was due a deceased SSI recipient. This provision would be effective for benefits payable after May, 1986.

5. Loss of SSI Benefits Upon Entitlement to Early Aged Widows or Widowers Benefits (Section 112)

Section 112 provides that an individual, who would otherwise qualify for SSI on the basis of disability, or blindness, but is ineligible for SSI because they qualify for early aged widows or widowers benefits under social security, that such an individual would be deemed to be an SSI a recipient for Medicaid eligibility purposes. Effective October 1, 1987.

6. Eligibility of alien for SSI when sponsor is an agency or organization (Section 113)

Section 113 expands the current law's limitation on the eligibility of aliens for SSI. Section 113 would deny eligibility for SSI to aliens for three years after entry into the United States if the alien was sponsored for entry by an agency or organization unless the agency or organization is bankrupt or no longer in existence. As in present law, the proposal would not apply to those who become blind or disabled after entry, to refugees or to persons granted political asylum.

7. Treatment of Certain Couples in Medical Institutions (Section 114)

Section 114 provides that a State would not be required to apply the SSI rule that considers members of a couple sharing a room in a Medicaid institution as two eligible SSI individuals instead of a SSI couple if such rule would disadvantage either member of a couple in determining eligibility under other State programs under the Social Security Act. Effective immediately.

Provisions Relating to Emergency Assistance

8. Modifications of Interim Assistance Program (Section 121)

Section 121 expands the interim assistance reimbursement provision to include payment of the appropriate amount of retroactive SSI funds to the State, when the State has provided financial funds to SSI recipients whose SSI benefits were terminated or suspended and who subsequently are found eligible for those benefits. It would also include the use of the interim assistance mechanism when the recipient's SSI check has been lost or stolen, there has not been a prompt replacement by the Social Security Administration and the state or local agency provided emergency assistance until the SSI check is replaced by the Social Security Administration. Current law only relates to assistance provided prior to receipt of retroactive benefits after initial application.

9. Increased emergency advance payments for presumptively eligible individuals (Section 122)

Section 122 provides that emergency advance payments, which can be paid directly by a Social Security district office to those in need of immediate subsistence income be increased from a maximum of \$100 to a maximum of the monthly regular SSI benefit standard and, if any, State supplementary payment.

Provisions Relating to Group Living Facility Standard

10. Repeal of penalty against recipient where group living facility fails to meet applicable standards (Section 131)

Section 131 repeals, effective immediately, a provision of present law that requires that Federal SSI payments be reduced dollar-for-dollar for any payments made by a State to provide medical or remedial care on behalf of an SSI recipient who is in an institution that is not approved as meeting relevant State standards.

11. Study of alternative methods of promoting the establishment and effective enforcement of standards for group living facilities (Section 132)

Section 132 directs HHS and GAO to analyze alternatives to current law and report findings by January 1, 1988.

Provisions Related to the Blind

12. Special notice to blind SSI recipients (Section 141)

Section 141 requires that the Social Security Administration would provide applicants and recipients on the basis of blindness the option to receive a supplementary notice, i.e., by telephone or certified letter, of any decision, determination or other action taken or proposed to be taken with respect to his or her rights under the SSI program.

13. Technical amendment related to rehabilitation services for the blind (Section 142)

Section 142 provides that the blind receiving benefits under the SSI program would, as is now the case for disabled SSI recipients,

be allowed to continue to receive vocational rehabilitation services funded through the SSI program even if there is an improvement in their medical condition that results in their no longer qualifying for SSI.

14. Effective Date (Section 151)

Except as otherwise specifically provided, the provisions of the general SSI amendments (Title I of the bill) are effective April 1, 1987.

TITLE II—EMPLOYMENT OPPORTUNITIES FOR DISABLED AMERICANS

1. Permanent authorization of programs of benefits under Section 1619 (Section 201)

Section 201 permanently extends section 1619 of the Social Security Act which provides special cash benefits and/or Medicaid coverage for disabled individuals who are able to work despite the continuation of their impairments. Section 1619 is authorized through June 30, 1987 under present law.

2. Eligibility of certain disabled individuals for benefits during initial two months in certain institutions (Section 202)

Section 202 provides that if an individual has been eligible under the provisions of section 1619(a) or 1619(b) in the month before entering a public institution (except a penal institution) or a Medicaid facility, the individual may continue to receive benefits based on the full SSI benefit standard for up to 2 months.

3. Improvements in Section 1619 Program (Section 203)

Section 203 provides that a disabled individual with fluctuating income would be able to move from one category of eligibility to another, i.e., regular SSI, cash benefits under 1619(b) and Medicaid status under 1619(b). Simplifies work incentive provisions by repealing the one-time Trial Work Period and instead requires a medical review within a year of first month of 1619 eligibility.

Disabled individuals whose work attempt fails for health or other reasons or who otherwise lose eligibility, could be reinstated to SSI or 1619 eligibility within 12 months of their last month of 1619 eligibility and with certain medical review requirements after the reinstatement. Disabled individuals would not be limited to one reinstatement period in comparison to the one-time Trial Work Period and Extended Period of Eligibility in present law. Also provides that impairment related work expenses and other work related disregards would be considered in determining an individuals continuing eligibility for Medicaid under section 1619.

4. Notifications to applicants and recipients (Section 204)

Section 204 requires the Secretary to provide special notices to disabled SSI recipients of the availability of work incentive provisions under section 1619.

5. *Loss of SSI upon entitlement to child's insurance benefits based on disability (Section 205)*

Section 205 provides for continued Medicaid coverage for those individuals who lose their eligibility for SSI when their income increases because they become newly eligible or because of an increase in their benefits as an adult disabled child under social security.

6. *Medicaid eligibility for certain recipients of cash benefits under Section 1619 (Section 206)*

Section 206 provides that, in those States without automatic Medicaid eligibility for SSI recipients [209(b) States], Medicaid eligibility would continue for those SSI recipients who become eligible under section 1619 and were eligible in the prior month under the State's own Medicaid eligibility criteria.

7. *Effective Date (Section 207)*

The provision to permanently extend the section 1619 program is effective upon enactment. The remaining provisions of Title II, are effective on July 1, 1987.

II. SECTION-BY-SECTION EXPLANATION

TITLE I—GENERAL SSI AMENDMENTS OF 1986

Subtitle A—Treatment of Income and Resources

Sec. 101. *Exclusion of certain temporary income in retrospective accounting*

Present Law.—Under the present law, the amount of the initial SSI benefit check payable for the initial month of eligibility is based on the income of the SSI applicant in that (current) month. As a transition to the two month retrospective budgeting system that is used thereafter in determining the amount of SSI benefits, the same income amount that is used to determine benefits in the initial month of eligibility is used again to determine benefits in the second and third months of eligibility. Thereafter, benefits are determined on the basis of income received in the second prior month.

The result of the procedure for transition from current month budgeting in the month of initial eligibility to two months retrospective budgeting is the SSI recipients have the same funds counted as income three times, even though the income may be temporary and received only in the first month.

Committee Bill.—Requires that temporary non-recurring income received in the initial month of eligibility or re-eligibility by SSI recipients may not be counted more than once under the retrospective accounting process.

Sec. 102. *Exclusion of certain real and personal property from income*

Present Law.—Under current SSI law real or personal property received is counted as income in the month it is received even if the property received would not be counted as a resource in the fol-

lowing months. This policy may have unduly harsh results. For example, this has resulted in a case where a disabled individual receiving SSI was married, and the value of the wedding gifts in the form of kitchen utensils that were received reduced her SSI benefits.

Committee Bill.—Provides for excluding from countable income certain unearned income received in the form of real or personal property which would not be counted as a resource in the following month.

Sec. 103. Modification of penalties where assets are transferred at less than fair market value

Present Law.—Since 1981, the SSI and Medicaid laws have limited eligibility for SSI and Medicaid where an individual sells or gives away any countable resource at less than fair market value.

Current law provides that an individual (or eligible spouse) who gives away or sells any nonexcludable resource for less than fair market value for the purpose of establishing SSI or Medicaid eligibility will have any uncompensated value of that resource (the difference between fair market value at the time of the transfer and the amount received for the resource) counted toward the resources limit of \$1,700 for an eligible individual and \$2,550 for a couple for a period of 24 months from the date of transfer. Fair market value is equal to the current value of a resource at the time of transfer. The transfer of a resource at less than fair market value is presumed to be for the purpose of establishing SSI or Medicaid eligibility unless the individual (or eligible spouse) can present convincing evidence that the transfer was exclusively for some other reason.

In 1982, Medicaid law was changed to provide an exception to the 24 month period of ineligibility from the date of transfer. Under the new law, states are allowed to waive the delay of Medicaid eligibility in cases of undue hardship.

Committee Bill.—There would be no effect on eligibility determination unless the amount of the total uncompensated value of the resources given as gifts or sold exceeds \$3,000. The intent of the amendment is to prevent penalizing low income aged, blind or disabled individuals with very limited resources, but to retain the provisions in current law which are intended to prevent cases of abuse by those with substantial resources. In addition, in cases where there would otherwise be a denial of benefits, the amendment provides that the Secretary of HHS would have the authority to waive the denial to the extent necessary to avoid undue hardship. Such a waiver or reduction of period of ineligibility could be made in cases where the SSI applicant or recipient is unable to recover the resources which he or she has given away or is unable to obtain full payment for resources he or she sold at less than current market value.

In a study of transfer of resources by SSI applicants, the Social Security Administration found that in several cases the transferors were relying heavily upon seemingly self-serving advice they received from the benefactor. The Committee believes that the aged, blind or disabled individual or couple who has innocently taken the advice of such an individual and transferred resources at less than current market value should not be denied needed cash assistance

and often more importantly, eligibility for medicaid. Thus, the waiver authority could also be used to protect innocent aged, blind or disabled individuals who may have been exploited in such a manner.

Subtitle B—Provisions Related to Eligibility

Sec. 111. Payment of benefits due deceased recipients

Present Law.—Present law provides that only an eligible spouse may receive the retroactive payment that was due a deceased SSI recipient. During the time that it takes SSA to process an SSI application, there have been cases where the SSI recipients has died before receiving the SSI retroactive payment. Even if he/she is subsequently found to be eligible, the only person that can receive a retroactive payment is his/her spouse if the spouse is also eligible for SSI. Where there is no eligible spouse, there is no payment.

Committee Bill.—Provides for payment of benefits on behalf of a deceased SSI recipient to an ineligible spouse of a deceased recipient and to the parent of a disabled or blind child who has died. Effective for benefit payable after May 31, 1986.

Sec. 112. SSI Benefits Entitlement to Early Aged Widows or Widowers Benefits

Present Law.—SSI Law requires that an individual apply for all other benefits for which he is eligible. Thus, at age 60, those disabled widow/ers who apply for or receive SSI, are required to apply for early aged widow/ers' social security benefits. (These benefits are actuarially reduced.) In cases where the resulting title II benefit is sufficient to preclude further SSI eligibility, the individuals lose Medicaid coverage. He/she does not qualify for Medicare benefits until age 65. In this case, a proportionately small increase in cash income results in the loss of far more valuable medical coverage.

Committee Bill.—The amendment provides that individuals who: are not eligible for Medicare; are between the ages of 60 and 65; qualify for early aged widows or widowers benefits under Title II; and who would be eligible for SSI except for the fact that they are required to apply for and receive social security benefits under the early aged widows or widowers program, shall be deemed to be SSI recipients for the purposes of the Medicaid program. The provision would be effective beginning October 1, 1987.

Sec. 113. Eligibility of alien for SSI when sponsor is an agency or organization

Present Law.—Under present law, the income and resources of the individual who sponsored an alien's entry into the United States and signed an affidavit of support, shall be considered in determining the eligibility for and the amount of SSI benefits payable to such alien. After disregarding an amount of the income and resources limitations to allow for the needs of the sponsor and his family, the remainder is deemed to be available for the support of the alien for a three year period after entry into the United States. This provision of current law does not apply to those who become

blind or disabled after entry, to refugees, and to persons granted political asylum.

Committee Bill.—Expands the current law's limitation on the eligibility of aliens for SSI. Section 113 would deny eligibility for SSI to aliens for three years after entry into the United States if the alien was sponsored for entry by an agency or organization unless the agency or organization is bankrupt or no longer in existence. As in present law, the proposal would not apply to those who become blind or disabled after entry, to refugees or to persons granted political asylum.

Sec. 114. Treatment of certain couples in medical institutions

Present Law.—States are generally required to follow SSI rules and interpretations in determining eligibility for nursing home care. These rules apply whether or not an individual or couple is eligible for SSI. Until August, 1985, when both members of a couple lived together in a nursing home, they were still treated as a couple and their income and assets were counted together in determining their eligibility.

These rules were changed in August, 1985, to consider members of a couple as eligible as separate individuals and their income and resources to be considered separately even when they lived together in a nursing home. The new rules were to the advantage of most couples because the amount of assets that two individuals can have and still be eligible is more than for a couple. However, for a few couples the new rules made one of them ineligible for nursing home care because the income of one member of the couple exceeded the individual income eligibility limit in a State for nursing home care.

Committee Bill.—Provides that a State would not be required to apply the SSI rule that considers members of a couple sharing a room in a medical institution as two eligible SSI individuals instead of a SSI couple if such rule would disadvantage either member of a couple in determining eligibility under other State programs under the Social Security Act.

Subtitle C—Provisions Relating to Emergency Assistance

Sec. 121. Modification of Interim Assistance Program

Present Law.—Current SSI law gives SSA the authority to enter into "interim assistance" agreements with States whereby, if an individual has been provided assistance (non-Federally matched) during the interim between the time of application for benefits and payment of retroactive SSI benefits, the State will be reimbursed from the retroactive SSI check for the assistance provided during the interim period.

Committee Bill.—Expands the interim assistance reimbursement provision to include payment of the appropriate amount of retroactive SSI funds to the State, when the State has provided financial funds to SSI recipients whose SSI benefits were terminated or suspended and who subsequently are found eligible for those benefits. It would also include the use of the interim assistance mechanism when the recipient's SSI check has been lost or stolen and there has not been a prompt replacement by the Social Security Adminis-

tration of the SSI check and the state or local agency has provided emergency assistance to the SSI recipient.

Sec. 122. Increased emergency advance payments for presumptively eligible individuals

Present Law.—Under present law, presumptively eligible aged, blind or disabled individuals or couples facing a financial emergency may receive an emergency cash advance of up to \$100 in the case of an individual and up to \$200 for a couple. Such advance payments are issued by District offices of the Social Security Administration. If the individual is subsequently determined to be eligible, the emergency advance payment is recouped in full from the SSI payment for the first month of eligibility. A related, but separate, provision of current law provides for the payment of full SSI benefits for three months prior to final determination of eligibility for SSI for those individuals who are found to be “presumptively disabled or blind”. However, such payments are not made immediately by the District offices compared to the emergency advance payments.

Committee Bill.—Provides that emergency advance payments which can be paid directly by a Social Security district office to those in need of immediate subsistence income be increased from a maximum of \$100 to a maximum of the monthly regular SSI benefit standard and, if any, State supplementary payment.

Subtitle D—Provisions Relating to Group Living Facility Standard

Sec. 131. Repeal of penalty against recipient where group living facility fails to meet applicable standards

Present Law.—Section 1616(e) requires States to establish, maintain and insure the enforcement of standards for institutions in which a significant number of SSI recipients reside. Present law also requires that Federal SSI payments be reduced dollar-for-dollar for any payments made by a State to provide medical or remedial care on behalf of an SSI recipient who is in an institution that is not approved as meeting relevant State standards.

This provision has been found to be unworkable. In addition, this requirement has been regarded by some as imposing a penalty on recipients, without putting effective pressure on the States to establish and maintain the necessary standards.

Committee Bill.—Repeals, effective upon enactment, the provision of present law that requires that Federal SSI payments be reduced dollar-for-dollar for any payments made by a State to provide medical or remedial care on behalf of an SSI recipient who is in an institution that is not approved as meeting relevant State standards.

Sec. 132. Study of alternative methods of promoting the establishment and effective enforcement of standards for group living facilities

Present Law.—No provision.

Committee Bill.—Provision directs HHS and GAO to analyze alternatives to current law and report findings by January 1, 1988.

Subtitle E—Provisions Related to the Blind

Sec. 141. Special notice to blind SSI recipients

Present Law.—There is no provision in current law requiring that individuals who are blind must receive special notice of official actions that may affect their benefits. Some blind individuals are unaware of the opportunities provided them by law to request consideration of a decision, or to request waiver of an overpayment.

Committee Bill.—Requires the Department of Health and Human Services to provide SSI recipients who are blind with the option of receiving special notice of official action which may affect their SSI benefit rights. The SSI recipient will be provided the option to receive a supplementary notice of any action by SSA by telephone or to receive the initial notice by certified letter. The amendment would provide that this option would be provided to all SSI applicants on the basis of blindness effective April 1, 1987. By October 1, 1987, the Secretary is to contact all current SSI recipients on the basis of blindness to provide them with option for a supplementary notice. It also requires the Secretary to conduct a study to determine the feasibility of providing supplementary notification rights to other individuals who may have difficulty in reading printed notices. These individuals may include the mentally impaired and persons for whom English is a second language.

Sec. 142. Technical amendment related to rehabilitation services for the blind

Present law.—No provision.

Committee Bill.—The amendment provides that the blind receiving benefits under the SSI program would, as is now the case for disabled SSI recipients, be allowed to continue to receive vocational rehabilitation services funded through the SSI program even if there is an improvement in their medical condition that results in their no longer qualifying for SSI.

Sec. 151. Effective Date

The amendments made by this title are effective April 1, 1987, unless otherwise noted.

TITLE II—EMPLOYMENT OPPORTUNITIES FOR DISABLED AMERICANS

Sec. 201. Permanent authorization of program of benefits under section 1619

Present Law.—In general, in order to be eligible for Supplemental Security Income (SSI) benefits based on disability, an individual must be unable to engage in "substantial gainful activity" (SGA). Current regulations have established that average countable earnings of over \$300 a month over an extended period, generally not less than six months, indicate that an individual is able to engage in SGA. In determining countable income for purposes of the SGA test, impairment related work expenses such as attendant care costs, the cost of medical devices, equipment and services, and drugs necessary to control the impairments are not counted.

Section 1619 of the Social Security Act authorizes a Supplemental Security Income (SSI) demonstration program under which spe-

cial cash benefits and/or Medicaid coverage are provided to disabled individuals who are able to engage in SGA in spite of severe medical impairments. Section 1619 authorization expires June 30, 1987.

Section 1619(a) provides that disabled SSI recipients with countable earned income of \$300 or more, but whose disabling impairment continues, remain eligible for income supplementation under SSI. In States that provide Medicaid eligibility for SSI recipients, section 1619(a) recipients are also eligible for Medicaid.

Section 1619(b) provides that a disabled or blind recipient with earned income, who becomes ineligible for SSI because of their income, but whose disabled impairment continues, can remain eligible for Medicaid as if they were still SSI recipients. To remain eligible for Medicaid under Section 1619(b), they must be otherwise eligible for SSI except for their earnings. There must also be a finding that the individual's earnings are not sufficient to allow him or her to have a reasonable equivalent of the value of SSI and Medicaid benefits which they would be eligible for if they were not working.

Committee Bill.—Makes Section 1619 a permanent provision of law effective upon enactment.

Sec. 202. Eligibility of certain disabled individuals for benefits during initial two months in certain institutions

Present Law.—An individual who is a resident of a public institution throughout a month is not eligible for SSI unless it is a Medicaid facility, a community-based residence serving no more than 16 persons or an emergency shelter (but for not more than 3 months care for an individual in any 12 month period).

When an individual enters a hospital, extended care facility, nursing home or intermediate care facility in which a major portion of the cost is paid by the Medicaid program, their monthly SSI benefit standard is reduced to \$25 beginning with the first full calendar month the individual is in such institution.

Individuals whose income from non-SSI sources exceeds the \$25 benefit standard, are not eligible for an SSI payment. This includes those who previously, when they were not living in a medical institution, were receiving some SSI because their social security benefits were less than the regular SSI benefit standard in that State.

Committee Bill.—Provides that if an individual has been eligible under the provisions of section 1619(a) or 1619(b) in the month before entering a public institution (except a penal institution) or a Medicaid facility, the individual will continue to receive benefits based on the full SSI benefit standard for up to 2 months.

Sec. 203. Improvements to Section 1619 Program

Present Law.—*Continuing Entitlement Related to Changes in Income:* An individual eligible for Medicaid under Section 1619(b) and with earnings at or above the \$300 substantial gainful activity (SGA) earnings level and whose total countable income decreases so that a cash payment under Section 1619(a) might be paid, cannot under present law, be directly reinstated to cash benefit status under 1619(a). The only way for him to be reinstated to cash benefit status would be to reduce his earnings to less than the SGA

earnings test level and seek reinstatement to a regular SSI benefit. If this occurs after the Extended Period of Eligibility, the individual would have to have his medical condition reevaluated for eligibility for regular SSI disability benefits.

Reinstatement: If an individual has been eligible under Section 1619 because of their earnings, and some event causes him or her to be ineligible for a month, the individual cannot return to 1619 status but must reestablish eligibility for regular SSI disability benefits. Temporary loss of eligibility may occur, for example, because of: one-time increases in earnings for a month; unearned income; excess resources; or changes in living arrangements, e.g., temporary hospitalization.

Reestablishing eligibility for regular SSI disability status usually requires a medical evaluation and always reducing earnings to less than the \$300 SGA earnings test. The exception to these reinstatement requirements is during the Trial Work Period and Extended Period of eligibility which is available only once to a disabled individual.

Trial Work Period: A disabled SSI recipient is permitted to work in up to nine months—not necessarily consecutive before a determination is made as to whether earnings are “substantial gainful activity (SGA). The Trial Work Period (TWP) provision requires determinations by SSA as to whether earnings in a particular month (over \$75) constitutes a month of trial work. Eligibility for regular SSI benefits is retained during this time as long as the individual’s unearned and earned income (as reduced by income disregards) does not exceed the SSI benefit standard.

When an individual completes a total nine months of trial work and is determined to be performing work constituting SGA, he or she loses eligibility for regular SSI benefits after three months after the ninth month.

If a disabled individual’s earnings are high enough to make him ineligible for a regular SSI benefit within the 9-month trial work period, the individual could become eligible for Medicaid under Section 1619(b). Coverage under Section 1619(b) would continue beyond the close of the TWP for as long as they meet the requirements of Section 1619, including the continued existence of the disabling impairment.

Medical Review: A medical review of the case to determine the continuance of the disabling impairment is undertaken at or near the end of the Trial Work Period.

Extended Period of Eligibility: Following the close of the Trial Work Period, there is an additional one-time 15 month period (consecutive months; working or not) of an Extended Period of Eligibility (EPE). During this period, an individual who has not been receiving a regular SSI payment because of work activities above the \$300 SGA level may be reinstated to regular SSI benefit status without having his medical condition reevaluated.

Countable Earnings and “Equivalent” Benefits in Determining Eligibility for Medicaid under Section 1619(b): One of the factors used in determining whether an individual is eligible for Medicaid under section 1619(b) is whether the earnings of the disabled or blind individual are sufficient to provide a “reasonable equivalent” of the SSI and Medicaid benefits that the person would have been

eligible for in the absence of such earnings. Income needed for approved plans for achieving self support (PASS) and impairment-related work expenses are not considered in determining "reasonable equivalent" of benefits.

Committee Bill.—In summary, the bill modifies present law as follows:

The bill would permit an individual to move from one category of eligibility to another, i.e., regular SSI, 1619(a) and 1619(b).

To simplify the work related provisions in SSI law, the bill repeals the Trial Work Period and Extended Period of Eligibility provisions in SSI law. It substitutes for the Trial Work Period and related determinations, a requirement for a medical review of an SSI disabled individual's case within 12 months of first becoming eligible for payments and/or medicaid on the basis of Section 1619. The purpose of the medical review would be to determine the continuation of the disabling impairment on the basis of which such individual was found to be under a disability.

The reinstatement provisions that are now a part of the one-time Trial Work Period/Extended Period of Eligibility would be modified as follows: For those individuals who seek reinstatement within 12 months of the last month of eligibility under Section 1619, immediate reinstatement to regular SSI or Section 1619(a) or 1619(b) would be granted. The individual must meet the other non-disability requirements under SSI or Section 1619 for reinstatement and would remain eligible until there is a finding that the individual no longer meets the requirements for eligibility including determinations from medical reviews. Unlike present law, the disabled individual would not be limited to one reinstatement period.

The bill also requires that the following be added to the consideration of whether an individuals earnings provide a "reasonable equivalent" of benefits which the individual otherwise would be entitled to in the absence of earnings: impairment related work expenses of the disabled; work expenses of the blind; cost of a plan for achieving self support (PASS); and publicly funded attendant care services or personal care assistance. It also requires that the "reasonable equivalent" of benefits criteria under section 1619(b), be based on information and data that are updated at least once a year.

Explanation: The permanent provisions relating to trial work and reinstatement and the temporary section 1619 provisions interact under current law. Their interaction is complicated and frequently requires the making of some eligibility determinations which are not productive inasmuch as they have no practical impact on the amount of benefits available to any individual. This makes it difficult to explain the effect of earnings to recipients and can cause inappropriate concern for recipients who are found ineligible for regular benefits even though they continue to qualify for special benefits.

Inasmuch as the Committee's bill would make permanent the provisions of section 1619, there appears no longer to be any practical purpose served by the trial work and automatic reentitlement provisions in the SSI program. Consequently, the Committee's bill would eliminate these features from the Supplemental Security

Income program. While this, in effect, means that an individual loses SSI eligibility in any month in which he demonstrates the ability to engage in substantial gainful activity, there is no actual loss to the individual since he automatically moves into special benefit status (unless his earnings are high enough to raise his total countable income above the level of eligibility for that status).

The Committee amendment also recognizes the reality that severely impaired individuals who make work attempts may not be able to follow a steady progression from SSI status, to special benefit status under section 1619(a), to medicaid only status under section 1619(b), and then to a status of complete independence. In practice, such individuals tend to undergo a more varied experience, often involving some setbacks which would require them to reestablish eligibility for an earlier category of benefits. To accommodate this reality, the Committee provides a relatively simple transition, in either direction, among the various categories of benefits. Actual determination of eligibility are only required in limited and specified circumstances (although the Secretary retains the discretion to review the continuing eligibility of recipients on a periodic basis and whenever there is an indication that there may have been a change in medical condition or other element of eligibility).

Further, the Committee amendment would make explicit in statute the current administrative practice, which requires the filing of a new application for SSI, only in cases where the individual has been ineligible for a period in excess of 12 consecutive months. While the 15-month automatic reentitlement period is being eliminated by these amendments, a disabled person who becomes ineligible for SSI or 1619 benefits for a period of 12 or fewer months may be reinstated without having first to be determined disabled.

The process under the Committee amendment is expected to operate in this manner:

An individual who has not previously been eligible for benefits under title XVI of the Social Security Act (or has not been so eligible within the past 12 months) must file an application for benefits to establish eligibility. Such an individual must, as under present law, be able to establish that he has a severe physical or mental impairment which prevents him from engaging in substantial gainful activity. The standards and procedures to be applied are those which apply under present law to both the supplemental security income and social security disability insurance program. (In addition he must sell all the non-disability-related requirements of the SSI program.) An individual who cannot establish eligibility on this basis cannot become eligible under the regular SSI program or under the special programs established by section 1619.

If an individual has become eligible on this basis for SSI benefits and then goes to work at an earnings level which equals or exceeds the level ordinarily considered to constitute substantial gainful activity (\$300 per month under current regulations), he will not be eligible in any month in which he has such earnings for a regular SSI benefit. However, he will be eligible for a special benefit under section 1619(a) which is exactly equal to the Federal SSI benefit which would be payable in that month on the basis of his actual total countable income.

Since there is no actual practical change in his benefit amount by reason of this special status, no determination with respect to his disability status is required at this point. (To the extent that his earnings represent a change in his total countable income, an income determination may be required as with any other income change.)

While there is no immediate requirement of a disability determination based on the fact that the recipient has begun to engage in substantial work activity, the Committee amendment does require that the individual's medical condition be reviewed within 12 months after he enters the special section 1619 status. The purpose of this review is to determine whether the individual continues to have the disabling physical or mental impairment on the basis of which he was first found eligible. If the individual has medically recovered, his eligibility for any benefits under title XVI, including section 1619, will be terminated. However, if he has not medically recovered (and still meets the non-disability requirements), he will be eligible for benefits under section 1619 even though he is no longer disabled to the extent of being unable to do significant work.

If an individual in 1619(a) status ceases to have earnings indicative of substantial gainful activity, benefits will be payable under the regular SSI provisions so long as he continues to have the disabling medical condition and meets non-disability eligibility requirements.

An individual receiving SSI or 1619(a) benefits may earn enough to increase his countable income to the point that he is ineligible for any further cash benefits. Assuming he has not medically recovered, he may be eligible for a special status in which no cash benefits are payable, but he retains medicaid eligibility. If his income subsequently declines, he may again begin receiving cash benefits under 1619(a) (if he continues to have earnings in excess of the amount ordinarily considered to constitute substantial gainful activity) or under the regular SSI provisions (if he no longer has earnings at that level).

The Committee amendment, thus, departs from current law by allowing an individual to move from 1619(b) status (medicaid only) back into cash benefit status (1619(a) or regular SSI) without first requiring a medical redetermination of SSI eligibility. However, a prompt review of his continuing medical eligibility is required in a such a case if in one or more of the 12 months before he returned to cash benefit status he had earnings at a level which (after applicable disregards) would be sufficient to reduce the Federal benefit amount to zero. A continuing review of medical eligibility is also required for an individual who reestablishes his eligibility for section 1619(b) status within a year of his last eligibility for that status. The requirement similarly applies only to those who in the month of reestablishing eligibility or in one or more of the prior 12 months has earnings which would be sufficient (after disregards) to reduce the Federal benefit to zero.

When a continuing disability review is required for an individual moving from medicaid only to cash benefit status (or reestablishing eligibility for the medicaid status), the standard for the review will be the medical review standard established by the 1984 disability amendments. The threshold question for such a review is whether

there is substantial evidence that there has been medical improvement in the individual's impairment (other than an improvement which is unrelated to ability to work).

If there has been no medical improvement (and all non-disability eligibility factors are met), the individual will continue to receive benefits. The statute spells out certain limited exceptions as in the current medical improvement criteria in SSI law, certain protections for those eligible under 1619 are provided in section 1614(a)(5)(B), and it is intended that such specific protections would also apply to those who are reinstated after up to 12 months of not being eligible under section 1619.

If there is substantial evidence that there has been medical improvement, the Social Security Administration will then make a determination as to whether the individual continues to be unable to engage in substantial gainful activity by reason of a severe, medically determinable impairment. If the individual is found no longer disabled under this standard, his benefits will terminate and he will no longer be eligible for any SSI benefits or any benefits under section 1619 (a) or (b) and cannot reestablish eligibility for any such benefits except on the basis of a new application for initial entitlement.

Sec. 204. Notifications to applicants and recipients

Present Law.—No provision.

Committee Bill.—Requires the Secretary of Health and Human Services to notify automatically any individual receiving SSI on the basis of disability of his or her potential eligibility under section 1619 at the following times:

- at the time of the initial award of eligibility;
- when the individual's earned income first exceeds \$200 per month; and
- periodically thereafter, so long as the individual has earned income of over \$200 a month.

Would exclude from notification persons under age 18 and would permit the Secretary to limit the frequency of notices. In addition to requiring special notices regarding the section 1619 program, the Committee also intends that the Social Security Administration establish a cadre of section 1619 specialist from staff within an area of field offices, and from staff of the appropriate Regional Office, if necessary, so that a section 1619 specialist is available to consult with each field office.

Sec. 205. Loss of SSI upon entitlement to child's insurance benefits based on disability

Present Law.—After an initial \$20 income disregard, social security disability insurance benefits are countable income in determining an individual's eligibility for SSI benefits.

A monthly benefit is payable under the social security disability insurance program to a disabled person age 18 or older and whose disability began before the age of 22, if the person is the son or daughter or eligible grandson or granddaughter of a retired, deceased or disabled worker.

The percent of the primary insurance amount (PIA) which is paid to the disabled adult child of a deceased worker is 75% com-

pared to 50% in the case of the disabled adult child of a retired or disabled worker.

Except in those 14 States where the State has chosen different Medicaid eligibility criteria, SSI recipients are eligible for Medicaid. They may also qualify for Medicaid in the 14 States, but not because they are SSI recipients. A disabled adult child must have been eligible for disability benefits under social security for 24 months before they are eligible under Medicare.

Committee Bill.—Provides for continued Medicaid coverage for those individuals who lose their eligibility for SSI when their income increases because they become newly eligible for social security benefits as an adult disabled child or because of an increase in their benefits as an adult disabled child.

Sec. 206. Medicaid eligibility for certain recipients of cash benefits under section 1619

Present Law.—In what are commonly referred to as section 209(a) States, the State determines Medicaid eligibility for aged, blind or disabled persons using more restrictive criteria than that of the SSI program. Those criteria may not be more restrictive than those in effect on January 1, 1972 under the Federal-State adult assistance programs for the aged, blind, and disabled. There are currently 14 209(b) States: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Utah, and Virginia. This means that section 1619 participants in 209(b) States are not automatically entitled to Medicaid coverage. They may be subject to more restrictive Medicaid eligibility requirements either by virtue of the disability eligibility test of the income and resources eligibility criteria.

Committee Bill.—Mandates continued Medicaid coverage in 209(b) States to those SSI recipients who were eligible for Medicaid, under a State's more restrictive criteria, beginning with the time they became eligible under section 1619.

Sec. 207. Effective Dates

The provision in section 201 to make the section 1619 program permanent is effective upon enactment. The other provisions in Title II are effective July 1, 1987.

III. VOTE OF THE COMMITTEE AND OTHER MATTERS TO BE DISCUSSED UNDER THE RULE OF THE HOUSE

In compliance with the subdivision (B) of clause 2(1)(2) of Rule XI of the Rules of the House of Representatives, the Committee states that the bill was approved by voice vote.

In compliance with subdivision (A) clause 2(1)(3) of Rule XI, the Committee reports that the amendments are consistent with the oversight findings of the Committee on Ways and Means and the explanations of the amendments contained in the section of this report.

In compliance with subdivision (D) of clause (2)(1)(3) of Rule XI, the Committee states that no oversight findings or recommenda-

tions have been submitted by the Committee on Government Operations with respect to the subject matter contained in the bill.

In compliance with clause (2)(1)(4) of Rule XI, the Committee estimates that enactment of the bill will have no inflationary impact of the economy.

In compliance with subdivision (B) of clause (2)(1)(3) of Rule XI, the Committee states that the bill does not increase tax expenditures and that a discussion of budget authority is contained in the report of the Congressional Budget Office.

In compliance with clause 7(a) of Rule XIII, the following statement is made relative to the budget effects of the provisions of H.R. 5595, as reported by the Committee:

With respect to the provisions contained in the bill, the Committee states that it agrees with the estimates of the Congressional Budget Office. These estimates are presented for fiscal years 1986 to 1991 for the unified budget.

In compliance with subdivision (C) of clause (2)(1)(3) of Rule XI, the Committee states that the Congressional Budget Office has examined H.R. 5595, as reported by the Committee and has submitted the following statements:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 24, 1986.

Hon. DAN ROSTENKOWSKI,
Chairman, House Committee on Ways and Means, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for the SSI Improvement Amendments of 1986, as ordered reported by the House Committee on Ways and Means on September 23, 1986.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,
Sincerely,

JAMES BLUM
(For Rudolph G. Penner).

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: H.R. 5595.
2. Bill title: SSI Improvement Amendments of 1986.
3. Bill status: As ordered reported by the House Committee on Ways and Means on September 23, 1986.
4. Bill purpose: To amend Title XVI of the Social Security Act to make necessary improvements in the SSI program with the objective of assuring such program (including the work incentive provisions in section 1619 of such Act) will more realistically and more equitably reflect the needs and circumstances of applicants and recipients thereunder.
5. Estimated cost to the Federal Government:

	1987	1988	1989	1990	1991
Required budget authority	-1	-5	2	7	10
Estimated outlays	-1	-5	2	7	10

Basis of Estimate.—Estimates for each of the sections of the bill are shown in Table I. The provisions have various effective dates; several are effective upon enactment, most are effective on April 1, or July 1, 1987, and one is not effective until October 1, 1987. This discussion deals with only those provisions that are estimated to cost or save more than \$500,000 a year.

Section 111 of the bill provides that retroactive benefits due to deceased SSI recipients be paid to ineligible (non-SSI) spouses and to the parent(s) of a disabled or blind child. Under current law, those retroactive benefits can go only to spouses receiving SSI. Retroactive benefits due deceased recipients total about \$6 million a year. Most SSI recipients do not live with a spouse or parent of that the provision is estimated to cost only \$1 million a year.

TABLE 1.—ESTIMATED FEDERAL OUTLAYS

(By fiscal year, in millions of dollars)

	1987	1988	1989	1990	1991
TITLE I: GENERAL SSI AMENDMENTS					
Subtitle A: Treatment of Income Resources					
Section 101. Exclude Temporary Income in Retrospective Budgeting ..	(1)	(1)	(1)	(1)	(1)
Section 102. Exclude Certain Real & Personal Property from Income..	(1)	(1)	(1)	(1)	(1)
Section 103. Modify Penalties for Transfer of Assets Below Market...	(1)	(1)	(1)	(1)	(1)
Subtitle B: Provisions Relating to Eligibility					
Section 111. Give Retroactive Benefits Due the Deceased to Relatives	1	1	1	1	1
Section 112. Give Medicaid to Disabled Widows to Age 65 When They Move From SSI to OASDI (effective 10/1/87) Medicaid.....	0	1	4	6	8
Section 113. Limit SSI Receipt for 3 Yrs. to Aliens Whose Sponsors Are Agencies/Organizations.....	(1)	(1)	(1)	(1)	(1)
Section 114. Allow States Flexibility in the Treatment of Couples in Medicaid Institutions Medicaid.....	(1)	(1)	(1)	(1)	(1)
Subtitle C: Provisions Relating to Emergency Assistance					
Section 121. Extend Interim Assistance.....	0	0	0	0	0
Section 122. Expand Emergency Payments.....	(1)	(1)	(1)	(1)	(1)
Subtitle D: Provisions Relating to Group Living Facility Standards					
Section 131. Repeal Penalty for Group Living Standards.....	(1)	(1)	(1)	(1)	(1)
Section 132. Study Group Living Standards.....	(1)	(1)	0	0	0
Subtitle E: Provisions Relating to the Blind					
Section 141. Give Special Notice to Blind	(1)	(1)	(1)	(1)	(1)
Section 142. Continue Voc Rehab when No Longer Eligible for SSI	(1)	(1)	(1)	(1)	(1)
TITLE II: EMPLOYMENT OPPORTUNITIES FOR DISABLED AMERICANS					
Section 201. Make Permanent Sections 1619 a and b:					
SSI	-3	-14	-16	-17	-19
Medicaid.....	1	4	5	5	5
Subtotal	-2	-10	-11	-12	-14
Section 202. Increase SSI Benefits to 1619 Eligibles When Institutionalized	(1)	(1)	(1)	(1)	(1)

TABLE 1.—ESTIMATED FEDERAL OUTLAYS—Continued

[By fiscal year, in millions of dollars]

	1987	1988	1989	1990	1991
Section 203. Repeal Trial Work Period, Extend Period of Eligibility, and Other Changes for 1619 Participants:					
SSI.....	(¹)	(¹)	(¹)	(¹)	(¹)
Medicaid.....	(¹)	(¹)	1	2	3
Subtotal.....	(¹)	(¹)	1	2	3
Section 204. Notify SSI Eligibles of 1619 Provisions.....	(¹)	(¹)	(¹)	(¹)	(¹)
Section 205. Provide Medicaid to Adult Kids Who Move from SSI to DI Medicaid.....	(¹)	3	7	10	12
Section 206. Provide Medicaid to 1619 Recipients Who Live in 109b States Medicaid.....	(¹)	(¹)	(¹)	(¹)	(¹)
Total all sections:					
SSI.....	-2	-13	-15	-16	-18
Medicaid.....	1	8	17	23	28
Total Federal outlays.....	-1	-5	2	7	10

¹ Less than \$500,000

Section 112 provides that certain disabled widows or widowers from the ages of 60 through 64 receive Medicaid benefits they would otherwise have lost. Current law requires that widows or widowers on SSI apply for OASDI benefits at age 60. If these benefits are high enough, they are ineligible for SSI and Medicaid but they are not eligible for Medicare until age 65. Costs are based on an estimated 3600 persons each year who would be affected by the bill, leading to federal costs rising from \$1 million in 1988 to \$8 million in 1991. The provision would not be effective until October 1, 1987.

Title II of the bill deals primarily with Section 1619 of the Social Security Act. The 1619 provisions permit disabled persons who work to retain SSI and/or Medicaid benefits in certain circumstances when their earnings would otherwise have made them ineligible. Section 201 permanently authorizes Section 1619, which was due to expire on July 1, 1987. The CBO estimate shows savings in SSI but costs in Medicaid. These estimates are based on a July 1986 study of Section 1619 by the Social Security Administration. The study found that an estimated 20 to 30 percent of 1619 participants would reduce their work activity in the absence of the 1619 protections. Section 1619 thus encourages some disabled participants to increase their earnings, which in turn reduces SSI.

A number of changes are made by Section 203, including repeal of the trial work period and the extended period of eligibility, the setting of standards for eligibility determinations for 1619 participants, and broadening of the Medicaid eligibility rules to include certain extraordinary expenses. The effect of SSI is estimated to be negligible while there would be a small estimated cost in Medicaid beginning in 1989.

Under Section 205, when a disabled adult child (an adult who was a disabled child) ceases to be eligible for SSI because of the receipt of OASDI benefits, the child's Medicaid benefits are continued. An estimated 5000 children every year incur such a change in status. An estimated one-third would have received Medicaid anyway. Medicaid costs are estimated to rise from a negligible

amount in 1987 to \$12 million in 1991, based on federal Medicaid costs per child of about \$1330 in 1987 and \$1610 in 1991.

6. Estimated cost to State and local governments:

	1987	1988	1989	1990	1991
SSI.....	(¹)	-1	-2	-2	-2
Medicaid.....	1	4	9	13	15
Total estimated State and local outlays.....	1	3	7	11	13

¹ Less than \$500,000.

The bill amendments would also affect state and local government budgets. Most states supplement the federal SSI benefit, so that their budgets are affected when the Congress enacts changes in SSI benefits. Permanent authorization of section 1619 would result in small state and local savings of \$1 million to \$2 million a year.

States share in the financing of Medicaid, accounting for 55 percent of program outlays on average. Their share of the Medicaid costs from the bills' various sections would rise from \$1 million in 1987 to an estimated \$13 million in 1991.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Janice Peskin and Don Muse.

10. Estimate approved by: James L. Blum, Assistant Director for Budget Analysis.

AMENDMENTS TO SECTION 1619 OF THE SOCIAL SECURITY
ACT

SEPTEMBER 22 (legislative day, SEPTEMBER 15), 1986.—Ordered to be printed

Mr. PACKWOOD, from the Committee on Finance,
submitted the following

REPORT

[To accompany S. 2209]

The Committee on Finance, to which was referred the bill (S. 2209) to make permanent and improve the provisions of section 1619 of the Social Security Act, which authorizes the continued payment of SSI benefits to individuals who work despite severe medical impairment; to amend such Act to require concurrent notification of eligibility for SSI and Medicaid benefits and notification to certain disabled SSI recipients of their potential eligibility for benefits under such section 1619; to provide for a GAO study of the effects of such section's work incentive provisions, and for other purposes, having considered the same, reports favorably thereon with an amendment and an amendment to the title and recommends that the bill as amended do pass.

I. SUMMARY

The Committee bill makes permanent and simplifies the special provisions of section 1619 of the Social Security Act which are designed to eliminate work disincentives for individuals who become eligible for supplemental security income by reason of blindness or disability and subsequently attempt to go to work. The bill as reported:

Makes Section 1619 a permanent feature of the law.

Allows beneficiaries of Section 1619 to receive up to 2 months of SSI benefits during temporary periods when they are in public institutions or Medicaid facilities.

Simplifies the transitions among regular SSI status, special benefit status under section 1619(a), and special Medicaid status under section 1619(b). Standards are established as to

when eligibility determinations must be conducted, and certain non-productive determinations are eliminated.

Modifies the Medicaid status rules to give appropriate consideration to certain extraordinary expenses; to assure that Medicaid is continued in States which do not automatically provide Medicaid to all SSI recipients; and to eliminate the loss of Medicaid in certain circumstances where such loss is caused by the award or increase of childhood disability benefits under title II of the Social Security Act.

Requires that SSI recipients be appropriately informed of the availability of section 1619 benefits.

II. GENERAL DESCRIPTION OF THE BILL

BACKGROUND AND REASON FOR CHANGE

The social security disability program is based on the concept that the benefit provided compensates for the loss of the individual's ability to earn because of his disability. The same concept applies to the supplemental security income (SSI) program, that is, an individual is qualified for cash assistance when his physical or mental condition will not permit him to provide for his basic needs through work effort.

Less severely handicapped individuals with limited ability to work also may receive assistance from a variety of governmental programs at the Federal, State, and local levels, but the Federal Social Security Act programs of disability insurance and supplemental security income were not designed to provide income support for individuals in that category.

While the Congress has found it necessary and important to limit eligibility under these programs to those who are so medically disabled that they cannot work, the Committee recognizes that some individuals determined to meet the Social Security Act definition of disability are nevertheless so motivated towards work and independence that they later manage to work in spite of their impairments.

Such individuals present a difficult dilemma for public policy. Allowing them to continue receiving income maintenance benefits would seem to undermine the fundamental Congressional decision that eligibility be limited to those who cannot work. This policy could lead to a far broader program which would not only be much more costly but would also raise serious policy issues.

On the other hand, terminating benefits in such circumstances can be a powerful disincentive to the work efforts which these severely disabled individuals are otherwise motivated to attempt. This is particularly a problem where supplemental security income eligibility (with its concomitant eligibility for Medicaid) is concerned. By definition, these programs deal with individuals who have limited resources to fall back on should their work attempts fail or prove insufficient to meet their medical and other needs.

In 1980, the Committee proposed and Congress enacted a new temporary program which addresses this dilemma. Entry into this program is limited to those individuals who have severe disabilities and have already been found on the basis of those disabilities to be

unable to work and, therefore, to be eligible for supplemental security income. When such individuals lose their eligibility for regular SSI benefits because they go to work at substantial gainful activity levels, they qualify for a special benefit which is equal in amount to the benefit which would be payable to an individual with the same income who was eligible for regular SSI benefits (that is, to an individual who had the same amount of countable income from a source other than earnings). To qualify for this special benefit, the individual must continue to have the same medical impairment on the basis of which he was originally found eligible and to continue meeting all SSI eligibility factors except for inability to engage in substantial work activity.

In addition, the special program adopted in 1980 allows SSI recipients who lose eligibility for SSI because they go to work to retain eligibility for Medicaid. This applies to those whose work activity indicates that they are no longer disabled and also to those with minimal employment which, when added to their income from sources other than earnings, causes their total income to exceed the SSI eligibility standards. Eligibility for this special Medicaid status is retained until the individual attains a level of earnings sufficiently high that he no longer requires Medicaid. As with the special benefit status, the special Medicaid status is only available to those who continue to have the medical impairment which was the basis for their initial SSI eligibility and who, except for their earnings, continue to meet all other eligibility factors.

Since SSI disability benefits are intended to provide income support for those with severe disabilities that prevent gainful work, it was not anticipated that the special program adopted in 1980 would affect a large proportion of the total SSI disability population. Nevertheless, the program has proven useful in removing disincentives to work for those recipients who are motivated to attempt work efforts despite apparently disabling medical conditions. The Committee believes that it is now appropriate to adopt this special program on a permanent basis.

In addition to making the program permanent, the Committee is making a number of modifications in the program. In general, these modifications are designed to simplify the way in which this special program works on the basis of the experience of the first several years. The changes should be viewed as streamlining the existing program. It is not the Committee's intent to expand the purpose of the program or to depart in any way from the original intent that this special work incentive provision should be viewed as a separate program for those who first have qualified for regular SSI benefits on the basis of their having a severe physical or mental impairment that prevents them from engaging in substantial gainful activity. It is not, and it is not intended to be, a step in the direction of a broader definition of disability for the social security programs. The Committee recognizes that section 1619, in providing benefits or Medicaid eligibility to some people who could no longer qualify as regular SSI applicants (because they have proven their ability to engage in substantial employment), will create some anomalous situations. The Committee believes however that the acceptance of some anomalies is a reasonable price to pay for a program which, without an expansion of the basic SSI program, re-

moves substantial disincentives to work attempts by the most highly motivated disability recipients.

PERMANENT AUTHORIZATION OF SECTION 1619

(Section 2)

Present law.—Section 1619 of the Social Security Act authorizes a demonstration program under which special cash benefits and Medicaid coverage are provided to individuals who lose their eligibility for SSI because they perform substantial gainful activity (SGA) in spite of severe medical impairments. By regulation countable earnings above \$300 a month generally are considered to show ability to engage in SGA. Section 1619(a) extends cash and Medicaid coverage to disabled individuals whose earnings preclude eligibility for regular SSI cash benefits. The amount of the cash payment under section 1619(a) is equal to the SSI benefit the individual would have received under the regular SSI program were it not for the SGA eligibility cut-off. An individual receiving cash benefits under 1619(a) is treated as an SSI recipient for Medicaid purposes. Section 1619(a) status is ended when the individual's countable income exceeds the amount which would cause the Federal SSI payment to be reduced to zero (based on the Federal benefit standard for an individual in 1986, the break-even point is \$757 a month). Section 1619(b) extends Medicaid coverage to disabled and blind individuals who lose SSI or section 1619(a) benefits because their income, although high enough to cause the loss of cash benefits may not be enough to replace the Medicaid benefits. Blind persons receiving SSI cash payments are, by law, not subject to the SGA test in determining their eligibility. Thus, blind SSI recipients do not need the protection of section 1619(a), but qualify for section 1619(b) protection. Section 1619, originally a 3-year demonstration program effective from January 1, 1981 through December 31, 1983, was enacted as part of P.L. 96-265 in 1980. The section 1619 program was extended through June 30, 1987 by P.L. 98-460 in 1984.

Committee amendment.—The Committee amendment would make section 1619 a permanent provision of law.

ELIGIBILITY OF CERTAIN DISABLED OR BLIND INDIVIDUALS FOR BENEFITS DURING INITIAL TWO MONTHS IN CERTAIN INSTITUTIONS

(Section 3)

Present law.—Aged, blind, or disabled individuals can be institutionalized for many reasons and for varying periods of time. Depending on the type of institution (public or private, medical or non-medical), the length of stay, and whether Medicaid benefits are paid on the individual's behalf, an individual can retain eligibility under the SSI program, lose eligibility, or be subject to a reduced payment standard. Generally, an individual who is an inmate of a public institution throughout any month, cannot be eligible for SSI. However, the law provides that an otherwise eligible individual who is, throughout any month, in a public or private hospital, extended care facility, nursing home, or intermediate care facility,

where a major portion of his care is paid for by the Medicaid program, can be eligible for SSI but is subject to a reduced SSI benefit of \$25 a month. Generally no payment is due to an eligible individual who is, throughout any month, an inmate of a public institution.

Committee amendment.—The Committee amendment provides that if an individual has been eligible under the provisions of section 1619(a) or 1619(b) in the month before entering either a public institution whose primary purpose is medical treatment (including mental institutions), or a Medicaid facility, the individual remains eligible for an SSI benefit payment based on the full federal benefit standard for up to 2 months. The additional 2 months of regular SSI payments are intended for the recipient's use in meeting expenses outside the institution (such as maintaining his place of residence). Therefore the institution or facility must agree that the recipient be permitted to retain benefits payable under this section for the provision to apply. This may be, for example, an individual agreement between the institution or facility and

(a) the recipient; or

(b) the local social security office; or

(c) particularly in the case of Medicaid facilities, the State.

The amendment includes a conforming requirement for Medicaid State plans to assure such benefits will be disregarded in determining the recipient's required contribution to the cost of care.

It is not the Committee's intent that individuals who are inmates of a penal institution, even if undergoing medical or psychiatric treatment in a hospital or other facility, will be covered by this provision.

The Committee deleted a bill provision requiring that district Social Security offices of sufficient size designate a 1619 specialist. The Committee urges the Secretary to establish a cadre of specialists from staff within an area of field offices, and from staff of the appropriate Regional Office, if necessary, so that a specialist is available to consult with each field office.

IMPROVEMENTS TO SECTION 1619 PROGRAM

(Section 4)

Present law.—The social security disability insurance program, which generally served as a model for the supplemental security income (SSI) disability program, addresses the problem of work disincentives by providing a nine-month trial work period during which beneficiaries who have not recovered medically can attempt employment without loss of benefits. If an individual is then determined to have regained the capacity for employment, benefits continue for an additional 3 months. Moreover, there is provided also a period during which a disabled individual may be reinstated to benefit status without a medical determination. The period begins after the close of the trial work period and runs for 15 months. These trial work and reinstatement provisions were also incorporated into the SSI program.

Since the 1980 amendments, SSI disability recipients who attempt to work also have had the benefit of the special benefit pro-

visions under section 1619 which have been in force as a temporary demonstration project.

Under subsection (a) of section 1619, an individual who becomes ineligible for SSI solely because he is engaging in substantial gainful activity (but has the same medical impairment on the basis of which he was found disabled) can receive a special benefit—equal to what he would be getting if he had the same income but was still eligible for SSI. Receipt of this special benefit will protect the individual's Medicaid eligibility if he resides in a State whose Medicaid plan uses SSI eligibility rules.

Under subsection (b) of section 1619, an individual who has earnings which increase his income above the SSI income eligibility level (whether or not his earnings are above the substantial gainful activity level) can retain Medicaid eligibility. Medicaid eligibility continues until the individual's income reaches a level where it is determined that his earnings are sufficient to provide an equivalency of the SSI and Medicaid benefits he would have if he were not working.

When an individual moves from SSI to section 1619(a) status, he has been determined to be no longer eligible for SSI. If he stops working (unless the reentitlement period applies) he must reestablish his eligibility under the initial benefit standards. Similarly, an individual who moves from 1619(a) status (special cash benefits) to 1619(b) status (Medicaid eligibility only) cannot move back into 1619(a) without first establishing eligibility to regular SSI benefits.

Committee amendment.—The permanent provisions relating to trial work and reinstatement and the temporary section 1619 provisions interact under current law. Their interaction is complicated and frequently requires the making of some eligibility determinations which are not productive inasmuch as they have no practical impact on the amount of benefits available to an individual. This makes it difficult to explain the effect of earnings to recipients and can cause inappropriate concern for recipients who are found ineligible for regular benefits even though they continue to qualify for special benefits.

Inasmuch as the Committee amendment would make permanent the provisions of section 1619, there appears no longer to be any practical purpose served by the trial work and automatic reentitlement provisions in the SSI program. Consequently, the Committee amendment would eliminate these features from the supplemental security income program. While this, in effect, means that an individual loses SSI eligibility in any month in which he demonstrates the ability to engage in substantial gainful activity, there is no actual loss to the individual since he automatically moves into special benefit status (unless his earnings are high enough to raise his total countable income above the level of eligibility for that status.)

The Committee amendment also recognizes the reality that severely impaired individuals who make work attempts may not be able to follow a steady progression from SSI status, to special benefit status under section 1619(a), to Medicaid only status under section 1619(b), and then to a status of complete independence. In practice, such individuals tend to undergo a more varied experience, often involving some setbacks which would require them to reestablish eligibility for an earlier category of benefits. To accom-

moderate this reality, the Committee provides a relatively simple transition, in either direction, among the various categories of benefits. Actual determinations of eligibility are only required in limited and specified circumstances (although the Secretary retains the discretion to review the continuing eligibility of recipients on a periodic basis and whenever there is an indication that there may have been a change in medical condition or other element of eligibility).

Further, the Committee amendment would make explicit in statute the current administrative practice which requires the filing of a new application for SSI only in cases where the individual has been ineligible for a period in excess of 12 consecutive months. While the 15-month automatic reentitlement period is being eliminated by these amendments, a disabled person who becomes ineligible for SSI or 1619 benefits for a period of 12 or fewer months may be reinstated without having to be first determined disabled.

The process under the Committee amendment is expected to operate in this manner:

An individual who has not previously been eligible for benefits under title XVI of the Social Security Act (or has not been so eligible within the past 12 months) must file an application for benefits to establish eligibility. Such an individual must, as under present law, be able to establish that he has a severe physical or mental impairment which prevents him from engaging in substantial gainful activity. The standards and procedures to be applied are those which apply under present law to both the supplemental security income and social security disability insurance program. (In addition he must meet all the nondisability-related requirements of the SSI program.) An individual who cannot establish eligibility on this basis cannot become eligible under the regular SSI program or under the special programs established by section 1619.

If an individual has become eligible on this basis for SSI benefits and then goes to work at an earnings level which exceeds the level ordinarily considered to constitute substantial gainful activity (\$300 per month under current regulation), he will not be eligible in any month in which he has such earnings for a regular SSI benefit. However, he will be eligible for a special benefit under section 1619(a) which is exactly equal to the Federal SSI benefit which would be payable in that month on the basis of his actual total countable income.

Since there is no actual practical change in his benefit amount by reason of this special status, no determination with respect to his disability status is required at this point. (To the extent that his earnings represent a change in his total countable income, an income determination may be required as with any other income change.)

While there is no immediate requirement of a disability determination based on the fact that the recipient has begun to engage in substantial work activity, the Committee amendment does require that the individual's medical condition be reviewed within 12 months after he enters the special section 1619 status. The purpose of this review is to determine whether the individual continues to have the disabling physical or mental impairment on the basis of which he was first found eligible. If the individual has medically

recovered, his eligibility for any benefits under title XVI, including section 1619, will be terminated. However, if he has not medically recovered (and still meets the non-disability requirements), he will be eligible for benefits under section 1619 even though he is not longer disabled to the extent of being unable to do significant work.

If an individual in 1619(a) status ceases to have earnings indicative of substantial gainful activity, benefits will be payable under the regular SSI provisions so long as he continues to have the disabling medical condition and to meet non-disability eligibility requirements.

An individual receiving SSI or 1619(a) benefits may earn enough to increase his countable income to the point that he is ineligible for any further cash benefits. Assuming he has not medically recovered, he may be eligible for a special status in which no cash benefits are payable, but he retains Medicaid eligibility. If his income subsequently declines, he may again begin receiving cash benefits under 1619(a) (if he continues to have earnings in excess of the amount ordinarily considered to constitute substantial gainful activity) or under the regular SSI provisions (if he no longer has earnings at that level).

The Committee amendment, thus, departs from current law by allowing an individual to move from 1619(b) status (Medicaid only) back into cash benefit status (1619(a) or regular SSI) without first requiring a medical redetermination of SSI eligibility. However, a prompt review of his continuing medical eligibility is required in such a case if in one or more of the 12 months before he returned to cash benefit status he had earnings at a level which (after applicable disregards) would be sufficient to reduce the Federal benefit amount to zero. A continuing review of medical eligibility is also required for an individual who reestablishes his eligibility for section 1619(b) status within a year of his last eligibility for that status. The requirement similarly applies only to those who in the month of reestablishing eligibility or in one or more of the prior 12 months had earnings which would be sufficient (after disregards) to reduce the Federal benefit to zero.

When a continuing disability review is required for an individual moving from Medicaid only to cash benefit status (or reestablishing eligibility for the Medicaid status), the standard for review will be the medical improvement standard established by the 1984 disability amendments. The threshold question for such a review is whether there has been "any medical improvement in the individual's impairment" (other than an improvement which is unrelated to ability to work).

If there has been no medical improvement (and all non-disability eligibility factors are met), the individual will continue to receive benefits. (The statute spells out certain limited exceptions, for example, in the case of new diagnostic techniques showing that the individual is less disabled than was originally determined.)

If there has been medical improvement, the Social Security Administration will then make a determination as to whether the individual continues to be unable to engage in substantial gainful activity by reason of a severe, medically determinable impairment. If the individual is found no longer disabled under this standard, his benefits will terminate and he will no longer be eligible for any SSI

benefits or any benefits under section 1619 (a) or (b) and cannot re-establish eligibility for any such benefits except on the basis of a new application for initial entitlement.

COUNTABLE EARNINGS AND "EQUIVALENT" BENEFITS

(Also Section 4)

Present law.—The law provides that one of the factors used in determining whether an individual is eligible for Medicaid benefits under section 1619(b) is whether the earnings of the disabled or blind individual are sufficient to provide a "reasonable equivalent" of the SSI and Medicaid benefits for which the person would have been eligible in the absence of such earnings. Separately the law requires the costs of impairment-related work expenses be disregarded in determining whether earnings constitute SGA, and requires impairment-related work expenses plus income needed for approved self-support plans to be disregarded in computing SSI benefit payments.

Committee amendment.—The Committee amendment requires that the value of publicly funded attendant care or personal care services be added to the consideration of whether an individual's earnings provide a "reasonable equivalent" of benefits which the individual otherwise would have been entitled to in the absence of earnings. The amendment also clarifies that federally administered State supplementary payments are to be considered in such a determination and also provides for the exclusion from earnings available to replace these benefits the cost of certain work expenses and the cost of achieving plans for self-support. Finally, the amendment requires that the "reasonable equivalent" of benefits criteria under section 1619(b) be based on information and data that are updated at least once a year.

SECTION 1619 ELIGIBILITY NOTICES

(Section 5)

Present law.—The law requires the Secretary of Health and Human Services to develop and disseminate to applicants for and recipients of SSI information on the potential availability of benefits and services for disabled individuals under section 1619.

Committee amendment.—The Committee amendment requires the Secretary of Health and Human Services to notify any individual receiving SSI on the basis of disability or blindness of his or her potential eligibility under section 1619 at the following times:

At the time of the initial award of eligibility (in the case of an individual 18 or over);

When the individual's earned income first equals or exceeds \$200 per month; and periodically thereafter, so long as the individual has earned income of \$200 or more a month, regardless of the age of the individual.

SOCIAL SECURITY CHILD'S BENEFITS

(Section 6)

Present law.—Under the Social Security Disability Insurance Program, a disabled person age 18 or over whose disability began before the age of 22, is eligible for a monthly disabled child's benefit if the person is the child or eligible grandchild or great grandchild of a retired, deceased, or disabled worker. Under the SSI program, social security benefits are considered unearned income and all but \$20 monthly is subtracted from the SSI payment. For example, in 1986 a disabled person receiving a disabled child's benefit of \$120 per month and no other income would receive a Federal SSI payment of \$236 per month and would have a total monthly income of \$356. A disabled person with a disabled child's benefit of \$356 or more a month would not receive an SSI payment.

Committee amendment.—The committee amendment provides for continued Medicaid coverage of those disabled or blind individuals who lose their eligibility for SSI when their income increases solely because they become newly eligible for social security benefits as an "adult disabled child" or because of an increase in their benefits as an adult disabled child. This means that a disabled or blind person who becomes entitled to an adult disabled child's benefit or an increase in such benefit that causes him or her to be no longer eligible for SSI would continue to be eligible for Medicaid benefits on the same basis as other SSI recipients.

SECTION 209(b) STATES

(Section 7)

Present law.—In what are commonly referred to as section 209(b) States, the State determines Medicaid eligibility for aged, blind, or disabled persons using more restrictive criteria than those of the SSI program. The criteria may not be more restrictive than those in effect on January 1, 1972 under the Federal-State adult assistance programs for the aged, blind, and disabled. There are currently 14 209(b) States: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Utah, and Virginia. This means that section 1619 participants in 209(b) States are not automatically entitled to Medicaid coverage. They may be subject to more restrictive Medicaid eligibility requirements either by virtue of the disability eligibility test or the income and resources eligibility criteria.

Committee amendment.—The Committee amendment mandates Medicaid coverage in 209(b) States to those who were eligible for Medicaid, under the more restrictive criteria, at the time they became eligible under section 1619.

EFFECTIVE DATE

(Section 8)

Present law.—Under present law the section 1619 program is scheduled to expire on June 30, 1987.

Committee amendment.—The Committee amendment makes the section 1619 program (section 2 of bill) permanent on enactment and makes the other sections of the bill effective as of July 1, 1987.

III. REGULATORY IMPACT OF THE BILL

In compliance with paragraph 11(b) of Rule XXVI of the Standing Rules of the Senate the following evaluation is made of the regulatory impact which would be incurred in carrying out the bill.

(A) The bill is not essentially regulatory in nature but simply modifies the requirements for an existing benefit program. The particular provisions dealt with by this bill are expected to directly affect a small percentage of the approximately 4 million recipients of supplemental security income.

(B) By eliminating disincentives to employment, the bill could have a significant personal economic impact on those disabled individuals affected, but the overall economic impact on consumers and businesses would be negligible.

(C) The bill should have no impact on personal privacy.

(D) To the extent that the bill mainly serves to streamline the processes for the existing program, there may be a minor reduction in the paperwork associated with operating the supplemental security income program.

IV. VOTE OF THE COMMITTEE IN REPORTING THE BILL

In compliance with paragraph 7 of Rule XXVI of the Standing Rules of the Senate, the following statement is made relative to the vote by the Committee to report the bill.

The bill was ordered reported by a voice vote.

V. BUDGETARY IMPACT OF THE BILL

In compliance with paragraph 11(a) of Rule XXVI of the Standing Rules of the Senate, the following statement is made relative to the costs and budgetary impacts of the bill.

The Committee adopts the estimates incorporated in the CBO analysis of the bill as shown below:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 18, 1986.

Hon. BOB PACKWOOD,
Chairman, Senate Committee on Finance,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for S. 2209, the Employment Opportunities for Disabled Americans Act.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,
Sincerely,

RUDOLPH G. PENNER, *Director.*

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 2209.
2. Bill title: Employment Opportunities for Disabled Americans Act.
3. Bill status: As ordered reported by the Senate Committee on Finance on September 10, 1986.
4. Bill purpose: To make permanent and improve the provisions of section 1619 of the Social Security Act, and for other purposes.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1986	1987	1988	1989	1990
Required budget authority.....	-2	-7	-3	(¹)	1
Estimated outlays.....	-2	-7	-3	(¹)	1

¹ Less than \$500,000.

Note: The effects of this bill would fall within budget functions 550 and 600.

Basis of Estimate: Estimates for each of the seven sections of the bill are shown in the table below. The effective date for the provisions is July 1, 1987, with the exception of making section 1619 permanent which is effective upon enactment.

ESTIMATED FEDERAL OUTLAYS BY SECTION

[By fiscal years, in millions of dollars]

	1987	1988	1989	1990	1991
Section 2:					
Make permanent sections 1619 a and b:					
SSI.....	-3	-14	-16	-17	-19
Medicaid.....	1	4	5	5	5
Subtotal.....	-2	-10	-11	-12	-14
Section 3:					
Increase SSI benefits to 1619 a and b eligibles when institutionalized.....	(¹)	(¹)	(¹)	(¹)	(¹)
Section 4:					
Repeal trial work period, extended period of eligibility, and other changes for 1619 participants:					
SSI.....	(¹)	(¹)	(¹)	(¹)	(¹)
Medicaid.....	(¹)	(¹)	1	2	3
Subtotal.....	(¹)	(¹)	1	2	3
Section 5:					
Notify SSI eligibles of 1619 provisions.....	(¹)	(¹)	(¹)	(¹)	(¹)
Section 6:					
Provide Medicaid to adult kids who move from SSI to DI: Medicaid....	(¹)	3	7	10	12
Section 7:					
Provide Medicaid to 1619 recipients who live in 209b States:					
Medicaid.....	(¹)	(¹)	(¹)	(¹)	(¹)
Total all sections:					
SSI.....	-3	-14	-16	-17	-19
Medicaid.....	1	7	13	17	20
Total outlays.....	-2	-7	-3	(¹)	1

¹ Less than \$500,000.

Section 2 of S. 2209 permanently authorizes Section 1619 of the Social Security Act, which was due to expire on July 1, 1987. The 1619 provisions permit disabled persons who work to retain SSI and/or Medicaid benefits in certain circumstances when their earnings would otherwise have made them ineligible. The CBO estimate shows savings in SSI but costs in Medicaid. These estimates are based on a July 1986 study of Section 1619 by the Social Security Administration. The study found that an estimated 20 to 30 percent of 1619 participants would reduce their work activity in the absence of the 1619 protections. Section 1619 thus encourages some disabled participants to increase their earnings, which in turn reduced SSI.

Section 3 allows Section 1619 participants to receive up to two months of SSI benefits when they are institutionalized. Currently, the institutionalized receive only \$25 a month from SSI. Because there are only about 10,000 participants in a month, and only a small fraction are institutionalized, costs of this provision would be negligible.

A number of changes affecting 1619 participants are made by Section 4, including repeal of the trial work period and the extended period of eligibility, the setting of standards for eligibility determinations, and broadening of the Medicaid eligibility rules to include certain extraordinary expenses. The effect on SSI is estimated to be negligible while there would be a small estimated cost in Medicaid beginning in 1989.

Section 5 requires that disabled persons be notified of the 1619 provisions at the time of their award of benefits and when their countable earned income is \$200 or more a month. Costs are estimated to be negligible.

Under Section 6, when a disabled adult child (an adult who was a disabled child) ceases to be eligible for SSI because of the receipt of OASDI benefits, the child's Medicaid benefits are continued. An estimated 5000 children every year incur such a change in status. An estimated one-third would have received Medicaid anyway. Medicaid costs are estimated to rise from a negligible amount in 1987 to \$12 million in 1991, based on federal Medicaid costs per child of about \$1330 in 1987 and \$1610 in 1991.

Section 7 requires that certain states ("209b" states) who set their own Medicaid eligibility standards provide Medicaid to 1619 participants. The cost is estimated to be negligible.

6. Estimated cost to State and local governments:

[By fiscal year, in millions of dollars]

	1987	1988	1989	1990	1991
SSI	(¹)	-1	-2	-2	-2
Medicaid	(¹)	3	6	8	9
Total estimated state and local outlays	(¹)	2	4	6	7

¹ Less than \$500,000.

The bill amendments would also affect state and local government budgets. Most states supplement the federal SSI benefit, so that their budgets are affected when the Congress enacts changes in SSI benefits. Permanent authorization of section 1619 would

result in small state and local savings of \$1 million to \$2 million a year.

States share in the financing of Medicaid, accounting for 55 percent of program outlays on average. Their share of the Medicaid costs from the bills' various sections would rise from a negligible amount in 1987 to a estimated \$9 million in 1991.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Janice Peskin.

10. Estimate approved by: C.G. Nuckols (for James L. Blum, Assistant Director for Budget Analysis).

VI. CHANGES IN EXISTING LAW

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Excerpt from Social Security Disability Amendments of 1980

SEC. 201. (d) The amendments made by subsections (a) and (b) shall become effective on January 1, 1981, but shall remain in effect only through June 30, 1987.

Excerpts from the Social Security Act

SEC. 1611. (e)(1)(A) Except as provided in subparagraphs (B), (C), (D) and [(D)] (E), no person shall be an eligible individual or eligible spouse for purposes of this title with respect to any month if throughout such month he is an inmate of a public institution.

(B) In any case where an eligible individual or his eligible spouse (if any) is, throughout any month, in a hospital, extended care facility, nursing home, or intermediate care facility receiving payments (with respect to such individual or spouse) under a State plan approved under title XIX, the benefit under this title for such individual for such month shall be payable (*subject to subparagraph (E)*)—

(i) at a rate not in excess of \$300 per year * * *

* * * * *

(E) *Notwithstanding subparagraphs (A) and (B), any individual who—*

(i) *is an inmate of a public institution, the primary purpose of which is the provision of medical or psychiatric care, throughout any month as described in subparagraph (A), or*

(II) *is in a hospital, extended care facility, nursing home, or intermediate care facility throughout any month as described in subparagraph (B),*

(ii) *was eligible under section 1619 (a) or (b) for the month preceding such month, and*

(iii) *under an agreement of the public institution or the hospital, extended care facility, nursing home, or intermediate care facility is permitted to retain any benefit payable by reason of this subparagraph,*

may be an eligible individual or eligible spouse for purposes of this title (and entitled to a benefit determined on the basis of the rate applicable under subsection (b)) for the month referred to in subclause (I) or (II) of clause (i) and, if such subclause still applies, for the succeeding month.

(F) An individual who is an eligible individual or an eligible spouse for a month by reason of subparagraph (E) shall not be treated as being eligible under section 1619 (a) or (b) for such month for purposes of clause (ii) of such subparagraph.

* * * * *

SEC. 1614. (a)(3)(A) * * *

* * * * *

(D) The Secretary shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. In determining whether an individual is able to engage in substantial gainful activity by reason of his earnings, where his disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, there shall be excluded from such earnings an amount equal to the cost (to such individual) of any attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary (as determined by the Secretary in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions; except that the amounts to be excluded shall be subject to such reasonable limits as the Secretary may prescribe. Notwithstanding the provisions of subparagraph (B), an individual whose services or earnings meet such criteria [, except for purposes of subparagraph (F) or paragraph (4),] shall be found not to be disabled.

(E) Notwithstanding the provisions of subparagraphs (A) through (D), an individual shall also be considered to be disabled for purposes of this title if he is permanently and totally disabled as defined under a State plan approved under title XIV or XVI as in effect for October 1972 and received aid under such plan (on the basis of disability) for December 1973 (and for at least one month prior to July 1973), so long as he is continuously disabled as so defined.

[(F) For purposes of this title, an individual whose trial work period has ended by application of paragraph (4)(D)(i) shall, subject to section 1611(e)(4), nonetheless be considered (except for purposes of section 1631(a)(5)) to be disabled through the end of the month preceding the termination month. For purposes of the preceding sentence, the termination month for any individual shall be the earlier of (i) the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (ii) the first month, after the period of 15 consecutive months following the end of such period of trial work, in which

such individual engages in or is determined to be able to engage in substantial gainful activity.]

[(G)] (F) In determining whether an individual's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under this section, the Secretary shall consider the combined effect of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity. If the Secretary does find a medically severe combination of impairments, the combined impact of the impairments shall be considered throughout the disability determination process.

[(H)] (G) In making determinations with respect to disability under this title, the provisions of sections 221(h), 221(k), and 223(d)(5) shall apply in the same manner as they apply to determinations of disability under title II.

[(4)(A)] For purposes of this title, any services rendered during a period of trial work (as defined in subparagraph (B)) by an individual who is an aged, blind, or disabled individual solely by reason of disability (as determined under paragraph (3) of this subsection) shall be deemed not to have been rendered by such individual in determining whether his disability has ceased in a month during such period. As used in this paragraph, the term "services" means activity which is performed for remuneration or gain or is determined by the Secretary to be of a type normally performed for remuneration or gain.

[(B)] The term "period of trial work", with respect to an individual who is an aged, blind, or disabled individual solely by reason of disability (as determined under paragraph (3) of this subsection), means a period of months beginning and ending as provided in subparagraphs (C) and (D).

[(C)] A period of trial work for any individual shall begin with the month in which he becomes eligible for benefits under this title on the basis of his disability; but no such period may begin for an individual who is eligible for benefits under this title on the basis of a disability if he has had a previous period of trial work while eligible for benefits on the basis of the same disability.

[(D)] A period of trial work for any individual shall end with the close of whichever of the following months is the earlier:

[(i)] the ninth month, beginning on or after the first day of such period, in which the individual renders services (whether or not such nine months are consecutive); or

[(ii)] the month in which his disability (as determined under paragraph (3) of this subsection) ceases (as determined after the application of subparagraph (A) of this paragraph).]

[(5)] (4) A recipient of benefits based on disability under this title may be determined not to be entitled to such benefits on the basis of a finding that the physical or mental impairment on the basis of which such benefits are provided has ceased, does not exist, or is not disabling only if such finding is supported by—

(A) substantial evidence which demonstrates that—

(i) there has been any medical improvement in the individual's impairment or combination of impairments (other

than medical improvement which is not related to the individual's ability to work), and

* * * * *

[(4) No benefit shall be payable under this title, except as provided in section 1619 (or section 1616(c)(3)), with respect to an eligible individual or his eligible spouse who is an aged, blind, or disabled individual solely by application of section 1614(a)(3)(F) for any month, after the third month, in which he engages in substantial gainful activity during the fifteen-month period following the end of his trial work period determined by application of section 1614(a)(4)(D)(i).]

* * * * *

Application and Review Requirements for Certain Individuals

(i) *For application and review requirements affecting the eligibility of certain individuals, see section 1631(j).*

* * * * *

SEC. 1619. (a)(1) *Except as provided in section 1631 (j), any [Any] individual who [is] was determined to be an eligible individual (or eligible spouse) by reason of being under a disability and was eligible to receive benefits under section 1611 [(b) or under this section for the month preceding the month for which eligibility for benefits under this section is now being determined, and who would otherwise be denied benefits by reason of section 1611(e)(4) or ceases to be an eligible individual (or eligible spouse) because his earnings have demonstrated a capacity to engage in] (or a federally administered State supplementary payment) for a month and whose earnings in a subsequent month exceed the amount designated by the Secretary ordinarily to represent substantial gainful activity, shall [nevertheless] qualify for a monthly benefit under this subsection for such subsequent month (which shall be in lieu of any benefit under section 1611) equal to an amount determined under section 1611(b)(1) (or, in the case of an individual who has an eligible spouse, under section 1611(b)(2)), and for purposes of title XIX [of this Act] shall be considered to be [a disabled individual] receiving supplemental security income benefits under this title, for so long as [the Secretary determines that]—*

[(1)] (A) such individual continues to have the disabling physical or mental impairment on the basis of which such individual was found to be under a disability[, and continues to meet all non-disability-related requirements for eligibility for benefits under this title]; and

[(2)] (B) the income of such individual, other than income excluded pursuant to section 1612(b), is not equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611 [(b) (if he were otherwise eligible for such payments)] and such individual meets all other non-disability-related requirements for eligibility for benefits under this title.

(2) *The Secretary shall make a determination under paragraph (1)(A) with respect to an individual not later than 12 months after*

the first month for which the individual qualifies for a benefit under this subsection.

(b)(1) *Except as provided in section 1631 (j), for [For] purposes of title XIX, any individual under age 65 who [, for the month preceding the first month in the period to which this subsection applies, received—*

[(i) a payment of supplemental security income benefits under section 1611(b) on the basis of blindness or disability,

[(ii) a supplementary payment under section 1616 of this Act or under section 212 of Public Law 93-66 on such basis,

[(iii) a payment of monthly benefits under subsection (a), or

[(iv) a supplementary payment under section 1616(c)(3),]
was determined to be a blind or disabled individual eligible to receive a benefit under section 1611 or any federally administered State supplementary payment for a month and who in a subsequent month is ineligible for benefits under this title (and for any federally administered State supplementary payments) because of his or her income shall, nevertheless, be considered to be [a blind or disabled individual] receiving supplemental security income benefits for [so long as] such subsequent month provided that the Secretary determines under regulations that—

[(1)] (A) *such individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which such he was found to be under a disability and, except for his earnings, [continues to meet] meets all non-disability-related requirements for eligibility for benefits under this title;*

[(2)] (B) *the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under 1611(b) (if he were otherwise eligible for such payments);*

[(3)] (C) *the termination of eligibility for benefits under title XIX would seriously inhibit his ability to continue his employment; and*

[(4)] (D) *such individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under this title [and] (including any federally administered State supplementary payments), benefits under title XIX, and publicly funded attendant care services (including personal care assistance), which would be available to him the absence of such earnings.*

(2)(A) *Determinations made under paragraph (1)(D) shall be based on information and data updated no less frequently than annually.*

(B) *In determining an individual's earnings for purposes of paragraph (1)(D), there shall be excluded from such earnings an amount equal to the sum of any amounts which are or would be excluded under clauses (ii) and (iv) of section 1612(b)(4)(B) (or under clauses (ii) and (iii) of section 1612(b)(4)(A)) in determining his or her income.*

(3) *In the case of a State that exercises the option under section 1902(f), any individual who—*

(A)(i) *qualifies for a benefit under subsection (a), or*

(ii) *meets the requirements of paragraph (1); and*

(B) was eligible for medical assistance under the State plan approved under title XIX in the month immediately preceding the first month in which the individual qualified for a benefit under such subsection or met such requirements shall remain eligible for medical assistance under such plan for so long as the individual qualifies for a benefit under such subsection or meets such requirements.

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SEC. 1631. (a) * * *

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Applications and Furnishing of Information

(e)(1)(A) The Secretary shall, subject to subparagraph (B), and subsection (j) prescribe such requirements with respect to the filing of applications, the suspension or termination of assistance, the furnishing of other data and material, as may be necessary for the effective and efficient administration of this title.

* * * * *

Application and Review Requirements for Certain Individuals

(j)(1) Notwithstanding any provision of section 1611 or 1619, any individual who—

(A) was an eligible individual (or eligible spouse) under section 1611 or was eligible for benefits under or pursuant to section 1619, and

(B) who, after such eligibility, is ineligible for benefits under or pursuant to both such sections for a period of 12 consecutive months,

may not thereafter become eligible for benefits under or pursuant to either such section until the individual has reapplied for benefits under section 1611 and been determined to be eligible for benefits under such section.

(2)(A) Notwithstanding any provision of section 1611 or section 1619, any individual who was eligible for benefits pursuant to section 1619(b), and who—

(i)(I) on the basis of the same impairment on which his or her eligibility under such section 1619(b) was based becomes eligible for benefits under section 1611 or 1619(a) for a month that follows a period during which the individual was ineligible for benefits under sections 1611 and 1619(a), and

(II) has earned income (other than income excluded pursuant to section 1612(b)) for any month in the 12-month period preceding such month that is equal to or in excess of the amount that would cause him or her to be ineligible for payments under section 1611(b) for that month (if he or she were otherwise eligible for such payments); or

(ii)(I) on the basis of the same impairment on which his or her eligibility under such section 1619(b) was based becomes eligible under section 1619(b) for a month that follows a period during which the individual was ineligible under section 1611 and section 1619, and

(II) has earned income (other than income excluded pursuant to section 1612(b)) for such month or for any month in the 12-month period preceding such month that is equal to or in excess of the amount that would cause him or her to be ineligible for payments under section 1611(b) for that month (if he or she were otherwise eligible for such payments); shall, upon becoming eligible (as described in clause (i)(I) or (ii)(I)), be subject to a prompt review of the type described in section 1614(a)(4).

(B) If the Secretary determines pursuant to a review required by subparagraph (A) that the impairment upon which the eligibility of an individual is based has ceased, does not exist, or is not disabling, such individual may not thereafter become eligible for a benefit under or pursuant to section 1611 or section 1619 until the individual has reapplied for benefits under section 1611 and been determined to be eligible for benefits under such section.

Notifications to Applicants and Recipients

(k) The Secretary shall notify an individual receiving benefits under section 1611 on the basis of disability or blindness of his or her potential eligibility for benefits under or pursuant to section 1619—

(1) at the time of the initial award of benefits to the individual under section 1611 (if the individual has attained the age of 18 at the time of such initial award), and

(2) at the earliest time after an initial award of benefits to an individual under section 1611 that the individual's earned income for a month (other than income excluded pursuant to section 1612(b)) is \$200 or more, and periodically thereafter so long as such individual has earned income (other than income so excluded) of \$200 or more per month.

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SEC. 1634. (a) * * *

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(c) If any individual who has attained the age of 18 and is receiving benefits under this title on the basis of blindness or a disability which began before he or she attained the age of 22—

(1) becomes entitled, on or after the effective date of this subsection, to child's insurance benefits which are payable under section 202(d) on the basis of such disability or to an increase in the amount of the child's insurance benefits which are so payable, and

(2) ceases to be eligible for benefits under this title because of such child's insurance benefits or because of the increase in such child's insurance benefits, such individual shall be treated for purposes of title XIX as receiving benefits under this title so long as he or she would be eligible for benefits under this title in the absence of such child's insurance benefits or such increase.

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SEC. 1902. (a) * * *

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(f) Notwithstanding any other provision of this title, except as provided in subsection (e) and section 1619(b)(3) no State not eligible to participate in the State plan program established under title XVI shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1903(f) (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to paragraph (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under paragraph (10)(A), or (2) an eligible individual or eligible spouse, as defined in title XVI, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under paragraph (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to paragraph (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection.

* * * * *

(1) Notwithstanding any provision of subsection (a) to the contrary, a State plan under this title shall provide that any supplemental security income benefits paid by reason of section 1611(e)(1)(E) to an individual who—

(1) is eligible for medical assistance under the plan, and

(2) is in a hospital, skilled nursing facility, or intermediate care facility at the time such benefits are paid, will be disregarded for purposes of determining the amount of any post-eligibility contribution by the individual to the cost of the care

and services provided by the hospital, skilled nursing facility, or intermediate care facility.

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REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

SEC. 1920. (a) **AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.**—For provisions of law which make additional individuals eligible for medical assistance under this title, see the following:

(1) **AFDC.**—(A) Section 402(a)(37) of this Act (relating to individuals who lose AFDC eligibility due to increased earnings).
(B) Section 406(h) of this Act (relating to individuals who lose AFDC eligibility due to increased collection of child or spousal support).

(C) Section 414(g) of this Act (relating to certain individuals participating in work supplementation programs).

(2) **SSI.**—(A) Section 1619 of this Act (relating to benefits for individuals who perform substantial gainful activity despite severe medical impairment).

(B) *Section 1634 of this Act (relating to individuals who lose eligibility for SSI benefits due to entitlement to child's insurance benefits under section 202(d) of this Act).*

(3) **FOSTER CARE AND ADOPTION ASSISTANCE.**—Section 473(b) of this Act (relating to medical assistance for children in foster care and for adopted children).

(4) **REFUGEE ASSISTANCE.**—Section 412(e)(5) of the Immigration and Nationality Act (relating to medical assistance for certain refugees).

(5) **MISCELLANEOUS.**—(A) Section 230 of Public Law 93-66 (relating to deeming eligible for medical assistance certain essential persons).

(B) Section 231 of Public Law 93-66 (relating to deeming eligible for medical assistance certain persons in medical institutions).

(C) Section 232 of Public Law 93-66 (relating to deeming eligible for medical assistance certain blind and disabled medically indigent persons).

(D) Section 13(c) of Public Law 93-233 (relating to deeming eligible for medical assistance certain individuals receiving mandatory State supplementary payments).

(E) Section 503 of Public Law 94-566 (relating to deeming eligible for medical assistance certain individuals who would be eligible for supplemental security income benefits but for cost-of-living increases in social security benefits).

(F) Section 310(b)(1) of Public Law 96-272 (relating to continuing medicaid eligibility for certain recipients of Veterans' Administration pensions).

(b) **ADDITIONAL STATE PLAN REQUIREMENTS.**—For other provisions of law that establish additional requirements for State plans to be approved under this title, see the following:

(1) Section 1618 of this Act (relating to requirement for operation of certain State supplementation programs).

(2) Section 212(a) of Public Law 93-66 (relating to requiring mandatory minimum State supplementation of SSI benefits program).



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